

Rehabilitation Care Workers’ Perceptions of the Outcomes of a Pilot Training Program

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In memory of Josh
our faithful friend and ray of sunshine

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Abstract

The South African National Development Plan (NDP) (National Planning Commission, 2011, p. 1) provides the road map for a reformed public health system by 2030. The proposed health system will be facilitated by, amongst others, training an appropriate balance of healthcare professionals including a cadre of community health workers (CHWs) that have a broad skills mix suited to reaching a larger number of people with first level intervention. With this in mind, a pilot group of CHWs were up-skilled as Rehabilitation Care Workers (RCWs). The training program was a joint project between the Division of Disability Studies and the Departments of Occupational Therapy, Physiotherapy and Speech and Language Therapy at UCT. **Problem:** Little is known about the perspectives of RCWs on the benefits and challenges of additional training in rehabilitation and disability related skills. **Rationale:** To inform the curriculum for a rehabilitation care worker (RCW) training program and the Western Cape Department of Health (WCDoH) of ways in which this cadre of worker could contribute to the realization of the 2030 Healthcare Plan. **Aim:** To describe the outcomes of a pilot RCW training program from the perspective of the pilot group of graduates. The objectives were to identify the areas of practice where RCWs feel competent/incompetent, to identify aspects of the health services where RCWs believe they can contribute the most/the least and to identify the facilitators/barriers they experienced when deployed in the health field. **Methodology:** A qualitative descriptive study was conducted. **Method:** Focus groups were carried out with three groups of six participants. **Findings:** The plot that permeated the participants' perspectives revolved around how the RCWs were *pioneers in breaking new ground* for the Western Cape Department of Health (WCDoH). Two themes informed the plot: *"we move health services to a new level"* and *"we manage change in new ways"*. **Discussion:** It is argued that the pilot RCW curriculum achieved its' objective of equipping a cadre of worker with basic rehabilitation, care and disability inclusion skills. While the envisaged role of RCWs in the health service and in making the NDP a reality is supported, it is argued that attention needs to be given to supervision structures and to training of all other health workers in order to promote inter professional practice. **Conclusions:** The pilot group of RCWs believe that they have acquired a new and large variety of skills that have enabled them to make a broad and positive impact in their places of work, at home and in the broader community.

Key Words: Community Health Workers (CHWs); Rehabilitation Care Workers (RCWs); Community Based Services (CBS); Intermediate Level of Care; Training Program.

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Abbreviations

CBR:	Community Based Rehabilitation
CBS:	Community Based Services
CCG:	Community Care Giver
CHBC:	Community and Home Based Care
CHW:	Community Health Worker
CRF:	Community Rehabilitation Facilitator
CRW:	Community Health Worker
CSP:	Comprehensive Service Plan
DOH:	Department of Health
HBC:	Home Based Care
HPCSA:	Health Professions Council of South Africa
LHW:	Lay Health Worker
MDG:	Millennium Development Goals
MLW:	Mid-Level Worker or Mid-Level Health Worker
NDoH:	National Department of Health
NDP:	National Development Program
NGO:	Non-Government Organization
NHP:	National Health Plan
NQF:	National Qualifications Framework
PHC:	Primary Health Care
RCW:	Rehabilitation Care Worker
UCT:	University of Cape Town
WCDoH:	Western Cape Department of Health

Chapter 1: Introduction

The South African National Development Plan (NDP) (National Planning Commission, 2011, p. 1) proposes a new path for South Africa, one that is expected to eliminate poverty and reduce inequality by 2030. The NDP aims to change the life chances of millions of South Africans whose lives have been stunted by our apartheid history. Change will be effected by creating a country wherein all citizens have the capabilities to grasp the ever-broadening opportunities available. By 2030, the NDP envisages a health system that provides quality health care to all, free at point of service, or paid for by publicly provided or privately funded insurance (National Planning Commission, 2011, p. 1, Western Cape Department of Health, 2013). Public health system reform will be facilitated by, amongst others, training an appropriate balance of healthcare professionals including a cadre of community health workers (CHWs) that have a broad skills mix suited to reaching a larger number of people with first level intervention. “The cadre of community-based health workers would undertake a range of health care activities, spanning the full breadth of rehabilitative/palliative care, treatment, preventative and promotive interventions. They would form the base of the health pyramid. In addition to rendering health care more accessible and equitable, this primary health care system will create more jobs and indirectly improve health by reducing the prevalence and depth of poverty” (National Planning Commission, 2011, p. 317).

In 2013, aware of the Healthcare 2030 directives, the Division of Disability Studies in the Department of Health and Rehabilitation Sciences at the University of Cape Town in the Western Cape Province of South Africa launched a one year pilot training program to up-skill community and home based carers (CHBCs) as rehabilitation care workers (RCWs). This qualitative study reports on the perspectives of the first cohort of 34 students on the benefits and challenges of the pilot RCW training program at the University of Cape Town (UCT).

1.1 Background to the Study

To achieve the proposed model of community-based health care, attention needs to be paid to the training and scope of practice of community-based health workers. Pinto et al., (2012, p. e74) suggests that “training should support collaboration between diverse providers and encourage all providers to follow CHWs’ lead, incorporating local knowledge into practice.”

Diverse rehabilitation professions including audiology, occupational therapy, physiotherapy and speech therapy are involved with the provision of comprehensive services for people with disabilities and for those persons at risk of developing disabling health conditions (National Rehabilitation Policy, 1996, p. 4). To date little documented attention has been paid by the rehabilitation professions to the collaborative design and delivery of a curriculum for RCWs. Little is known about the educational outcomes of a cross professional skills mix curriculum for RCWs that is suited to the first contact disability related needs of the population. Rehabilitation and disability is not synonymous. People with disabilities often require rehabilitation, but this is not all they need. Rehabilitation is often provided from a medical model perspective, and this can neglect the social model emphasis. People with disabilities face many physical and attitudinal barriers to their participation in society. It is these barriers which also need attention to promote participation, and it is these barriers which the social model of disability views as disabling (Chappell & Johannsmeier, 2009). The current CHW cadre in South Africa have been trained in amongst others, wound care and TB/HIV related services. They have not been trained in rehabilitation skills. It is these rehabilitation and disability inclusion skills that the RCW training programme aimed to teach.

The roll out of pilot re-engineering sites in the Eastern Cape has been fraught with difficulties (Ruresa, 2013; The Province of the Eastern Cape, 2011). In this regard, Pillay and Barron (2011) indicated that the current CHWs in the Eastern Cape who are on stipend are still to be up-scaled to become fully accredited CHWs, [i.e. they are not fully qualified] and that some issues related to CHWs still need to be addressed. These include: details of training, scope of practice, reporting lines to community and clinic, toolkits, and referral and admission protocols. While the ideal exists on paper, the reality of the working conditions of CRWs and CHWs has received attention from a range of authors (Lehman & Saunders, 2007; Chappell and Johannsmeier, 2009). Adequate supervision has frequently been a concern. Another concern is the fact that South Africa does not yet have an official policy on Community Based Rehabilitation (CBR), which means that health departments are left without comprehensive guidance.

In 2011 the WCDoH released a service plan, referred to as Healthcare 2020, for the provincial re-engineering of the Primary Health Care (PHC), (Western Cape Department of Health, 2011). The re-engineering of PHC creates a community based healthcare policy framework. It aims to

provide a seamless service between levels of care¹. The proposed seamless service will “potentially provide significant relief for acute and specialised hospitals, by providing appropriate interventions to help patients improve their functional ability once their acute medical condition has been stabilised” (Western Cape Department of Health, 2011, p. 29). There is also an intention that CHWs should function in primary health care (PHC) teams and “provide specific prevention and promotion activities that focus on promoting wellness” (Western Cape Department of Health, 2011, p. 29).

1.1.1 Use of Terminology

In order to introduce the reader to the multitude of terms used within the South African health sector, this section aims to clarify and explain the most important terminology used in this thesis. For the purpose of the study, the term RCW will be used, when referring to the new cadre of *rehabilitation care worker*, which this study is about.

Health Care workers (HCWs) are comprised of all categories or cadres of health care workers from specialist physicians and surgeons through to community health workers (Mwita, 2010, p. 2).

Mid-level Workers (MLWs) are health cadres who have been trained for shorter periods and required lower entry educational qualifications (Dawad & Jobson, 2011). They are frontline health workers in the community who are not doctors, but who have been trained to diagnose and treat common health problems, to manage emergencies, to refer appropriately and to transfer the seriously ill or injured for further care (Zohra, Cometto, Huicho, & Bhutta, 2013, p. 825). The titles which are commonly used to refer to MLHWs include physician assistant, medical assistant, health assistant, health officer, nurse practitioner, nurse assistant, dental auxiliary, clinical officer, physiotherapy assistant and dental technician (Mwita, 2010, p. 31).

Community Health Workers (CHWs) are workers with less training than professional workers, they should be from the communities they serve, selected by the communities they serve, answerable to those communities, and supported by the health systems but not necessarily formally part of the health systems (Mwita, 2010, p. 7).

¹ The levels of care refer to the different platforms of service delivery; Tertiary, Secondary and Primary. Primary level consists of both facility-based services and community-based services.

Community and Home Based Carers (CHBCs), often just called *home based carers*, are community health workers specifically trained amongst other duties, to assist with home care for patients needing care such as wound care and TB / HIV care. It was from this cadre of worker that the RCWs, about which this study was carried out, were selected.

Community Rehabilitation Workers (CRWs) are health workers that are trained in CBR programs. CBR is defined as ‘a strategy within a general community development for the rehabilitation, equalization of opportunities, poverty reduction and social inclusion of all PWD’ (Chappell and Johannsmeier, 2009, p. 1). The link between CRWs and RCWs is that the RCWs are trained in aspects of CBR as well as facility based services.

Community Rehabilitation Facilitators (CRFs) is a different terminology for CRWs.

Rehabilitation Care Workers (RCWs) are the new pilot group of CHWs in the Western Cape specifically trained to boost the community based services (CBS) level, which includes community and home based care as well as intermediate level of care.

Lay Health Workers (LHW) refers to health workers that are not necessarily remunerated, who work on a voluntary basis.

Community Based Services (at least in the Western Cape) refers to health services that are performed outside of health facilities. However, a confusing aspect is that it does include some facilities at the *intermediate level of care*. Examples of these facilities are Booth Hospital, Conradie Care, Tygerberg Hospice and Sarah Fox Convalescent Centre.

The International Classification of Functioning, Disability and Health, known as ICF, is a classification tool which belongs to the WHO family of international classifications and is designed to record and organize a wide range of information about health and health-related states. Besides research aims and coding systems, specific aims of the ICF according to WHO (2000) are: to provide a scientific basis for understanding and studying health and health-related states, outcomes and determinants and to establish a common language for describing health and health-related states to improve communication among health professionals, researchers, patients and other stakeholders in the health-care system.

Intermediate care facilities refers to facilities where in-patient transitional care, which facilitates optimal recovery from acute illness or complications of a long-term condition, enabling users to

regain skills and abilities in daily living with the ultimate discharge destination being home or an alternate supported living environment (Schneider, 2012, p. 14).

The terminology overlaps because there is not always a clear distinction between MLW and CHW. In South Africa mid-level workers tend to be formally registered with health boards, while CHWs are not, and MLWs usually receive more formal training than CHWs. The RCWs are CHWs (who were almost all previously trained CHBCs) who have been up-skilled. Whether they are going to be called mid-level workers or whether they will be recognized by the Health Professions Council of South Africa, is at this point in time unclear. The RCWs are not CRWs although there are aspects of CBR that they are trained to do.

1.1.2 Healthcare 2030: The Role of Community Health Workers

Part of the vision of Healthcare 2030 is that CHWs will work in PHC teams per allocated number of households in designated geographical areas. There will be a “focus on the care pathway for patients, which includes a continuum of care that is planned to meet the needs of individual patients, a map of the patient’s journey through the system for the entire health care intervention, and the consideration of the patient’s goals, needs and lifestyle. There will also be a focus on community involvement in health” (Western Cape Department of Health, 2013, p. 26). The focus of rehabilitation interventions in the Community Based Services (CBS) platform will be on the human functioning that relate to difficulties in executing activities (*activity limitations*) and problems in involvement in life situations (*participation restrictions*), [*Italics added to reflect International Classification of Health, Functioning and Disability terminology*], WHO, (2007).

CHWs are not trained in rehabilitation skills or community development. They had only received basic home based care training. Rehabilitation professionals working at the primary level of care have for many years been closely linked to the provincial Community and Home Based Care (CHBC) program. They have provided informal training to groups and individual CHWs, and have been a referral source for the CHWs to refer to and vice versa. Due to limited numbers of rehabilitation professionals, many CHWs or NGOs have not received in-service training or support. This means that the majority of CHWs in the Western Cape Province are not equipped to manage patients that require community-based rehabilitation or to deal with disability and developmental issues in their communities. The increased range of care interventions at the

community level envisaged by Healthcare 2030 would require the up-skilling and deployment of some CHWs as RCWs. The process of up-skilling would involve participation in a specifically designed² curriculum that trains CHWs in rudimentary disability practice, rehabilitation care, and support in line with the role and scope of this new cadre of community health worker. The development of the pilot training program at UCT aimed to up-skill a selected group of community health workers in the Cape Town Metro forms the backdrop for this study.

1.1.3 Pilot Training: Up-skilling of Community Health Workers as Rehabilitation Care Workers.

During 2012, the Western Cape Department of Health embarked on a pilot project to up-skill some CHWs to become RCWs. The CHWs, known as community and home based carers (CHBCs) are employed by NGOs and receive stipends. They are not employed directly by the WCDoH. The University of Cape Town was awarded the tender in August 2012, and started the pilot RCW training program of 34³ community health workers in 2013. The training involved a one year certificate program⁴ at National Qualifications Framework (NQF) level 5 (South African Qualifications Act, 1995). The pilot group of RCWs were extremely proud to have been selected for this training program, as the chance was highly unlikely they would ever have had the opportunity to attend a program at university level. Facilitators from the various rehabilitation professions and disability studies at UCT co-designed and presented modules on aspects of health wellness, functional ability, disability practice, rehabilitation, and health promotion. Practical training was provided at intermediate care facilities and various community based sites in the Cape Town Metro⁵. The pilot program was implemented in the Mitchell's Plain/Klipfontein Substructure and the Khayelitsha Substructure (see Appendix 1), with the intention to extend it to the other substructures of the Cape Town Metro and the potential to extend it nationally if

² “Essentially, the rehabilitation care worker is being seen as someone that will be broadly trained *across* the different rehabilitation fields of physiotherapy, occupational therapy, speech therapy, as well as having basic counselling skills” (Schneider, 2012, p. 58).

³ 34 CHWs started the training. Only 30 completed the course, and one has subsequently passed away.

⁴ This was an integrated curriculum, co-designed at the University of Cape Town (UCT) by the Division of Disability Studies and the Department of Health and Rehabilitation Sciences.

⁵ Examples of sites include Mitchell's Plain and Khayelitsha. See map – Appendix 1.

proven successful. Empirical evidence of the course benefits is needed to prove the value of the course, and thus motivate for approval of additional training programs. This study reports on the perceived outcomes of up-skilling for community based rehabilitation and disability related services by the pilot group of RCWs who were trained during 2013. The findings of the study provide an indication of how the RCWs perceive the outcomes of the training program for service provision at intermediate, community and home based levels of care.

1.1.4 Implications for Occupational Therapy

Occupational Therapy is centrally concerned with human functioning, especially with regards to dysfunctional occupational performance (*activity limitations*) and restricted occupational engagement (*participation restrictions*) in a target population's environment (World Health Organization, 2007; Farrell, Anderson, Hewitt, Livingston & Stewart, 2007). Given occupational therapy's theoretical and skill base in relation to humans as occupational beings, the profession is crucially linked to the curriculum outcomes of the RCWs. Through the use of the terminology and language of the ICF, and by partnering with this primary level programme, occupational therapy can be on the forefront of this vital developing field of service delivery in South Africa.

RCWs are not yet accredited with the Health Professions Council of South Africa (HPCSA). Professionals such as occupational therapists, physiotherapists and speech therapists as well as nurses and doctors will have to take accountability for the actions or inactions of RCWs. Supervision of each RCWs therefore needs to be done by a rehabilitation professional (Schneider, 2012, p. 59). This study contributes inputs from the views of newly trained RCWs about their perceptions of the outcomes of the training program regarding their contribution to the WCDoH, and facilitators and barriers to their deployment, and will therefore assist rehabilitation professions including occupational therapy with deliberations about the emergent role and scope of this new cadre of worker (Ruresa, 2013; Schneider, 2012; Versteeg & Couper, 2011).⁶

There remains a lot to be done regarding formalizing CHWs relationship with health professionals, as they are still employed via Non-Government Organizations (NGOs), do not

⁶ The supervision ratio's proposed are 6:1 (RCWs to professional therapist) and 8:1 (CHWs to RCWs).

participate in any benefits of full time employees in the WCDoH, with resultant disparities in conditions of employment. This creates a barrier on the outset between professionals in the health department and CRWs. The HPCSA has declined to accredit any CHW or other mid-level worker unless directly coupled to a profession – such as in the case of occupational therapy technicians. There also is no Community Based Rehabilitation (CBR) policy which can assist with the deployment of this new cadre of worker.

The pilot project implemented at the University of Cape Town in 2013 of deployment of RCWs has the potential to spearhead the way for formalizing employment structures/policies, supervision requirements, scope of practice issues, and assist in the effective re-engineering of the primary health care services, at least in the Western Cape. Ultimately the health and developmental needs of the country should take precedence over professional issues, without compromising standards. This research and more such research is needed to convince the HPCSA to increase their flexibility in their policy towards RCWs, as rehabilitation professionals, including occupational therapists, will be expected to supervise RCWs in the WCDoH.

1.2 Problem Statement

Little is known about the contribution of this cadre of CHW towards the National Healthcare Plan and only one other formal research study into the outcomes of RCW training has been conducted to date (Lufuluabo, 2013).

1.3 Purpose of the Study

The one year pilot training program for RCWs, implemented at the University of Cape Town in 2013, was the first of its kind in the Western Cape Province and South Africa. The pilot course could serve as a prototype for the roll out of similar curricula elsewhere in the country and in the Western Cape in particular. Knowing more about the outcomes of RCW training could guide managers in the optimal utilization of this cadre of worker, assist in improving health systems deficits and indirectly contribute to the potential success of the National Development Plan.

1.4 Research Question

What are the self-perceived outcomes of the pilot Higher Certificate in Disability Practice (Rehabilitation Care and Support) Course, for Rehabilitation Care Workers?

1.5 Aim of the study

To describe the outcomes of the pilot Higher Certificate in Disability Practice (Rehabilitation Care and Support) Course, from the perspective of new graduates.

1.6 Objectives of the Study

1. To identify the areas of practice where RCW's feel competent/incompetent.
2. To identify aspects of the health services where RCW's believe they can contribute the most / the least.
3. To identify the facilitators/barriers they experienced when deployed in the health field.

1.7 Summary

This chapter has provided a brief background to, and rationale for the study. Reference has been made to national and provincial health policies, including community health workers as part of human resource planning in the short and mid-term future. This chapter has proposed that RCWs contribution is directly linked to the National Health Plan (NHP) and the National Development Plan (NDP). Based on participants' perspectives, the outcomes of this study suggest that there are successes and shortcomings with regard to the training of this category of worker. The training of RCWs is valuable for occupational therapy, particularly with regard to the human functioning's that relate to difficulties in executing activities (*activity limitations*) and problems in involvement in life situations (*participation restrictions*) (WHO, 2007). In addition this study could be valuable to the provincial and national health department, the national planning commission, and the curriculum developers at UCT. The next chapter will review more literature relevant to the study, focussing on the community health worker curriculum, role and scope of practice.

Chapter 2: Literature Review

2.1 Introduction

The literature review commences with an exploration of the literature about community health workers internationally, in Africa, in South Africa and the Western Cape in particular. It considers their training needs and curriculum construction challenges. Literature was found on impacts of CBR workers, but this only slightly related to the current study. No literature was found on self-perceived outcomes of CHW training. The chapter concludes with an overview of pertinent policies concerned with CHWs as a human resource for the NHP.

2.2 Community Health Workers: Internationally

Community health workers (CHWs) have been in existence internationally for decades, however it was not until the Alma Ata conference in 1978 that the concept of CHWs was “universally adopted as a means for achieving the goal of health for all by the year 2000” (Mwita, 2010, p. 6). According to Mwita (2010, p. 6), the World Health Organization (WHO) has determined that in order to meet the revised Millennium Development Goals (MDGs) a larger load of health care services should be shifted to community and mid-level workers. In most African countries, up to 75% of the health care workers are community health workers and mid-level workers (Mwita, 2010, p. 2).

According to McCord, Liu and Sing, (2013, p. 244) CHW programs have documented success in sub-Saharan Africa and the costs are modest compared with the projected costs of the primary-health-care system. Government funded initiatives to extend the health workforce through training of CHWs, exist in Brazil, India and elsewhere in Africa (Pinto, 2012; Prinja, 2014; Drobac et al., 2013 & McCord, Liu & Sing, 2013). According to Pinto (2012) and Prinja (2014) there were cost benefits of community health worker programs in India and Brazil. The health needs of the populations in these countries correspond with South Africa, suggesting that South African CBS programs and CHW training are in line with international trends and evidence based practice (McCord, Liu & Sing, 2013). The design of CHW programs relies on the support and supervision of midlevel workers and the community. This has frequently not been the case, especially in Africa, and as supervision requirements increase in conjunction with categories of staff that are

less trained (Mwita, 2010, p. 4), CHW programs have been adversely affected (Mwita, 2010, p. 5).

2.3 Community Health Workers: South Africa

In South Africa, community health workers are recognized as a means of improving access to health care and encouraging community participation in health care in peri-urban and rural areas (Mayosi and Benatar, 2014, p. 6). The last 15 years have seen a greater involvement of non-governmental organizations (NGOs) supporting government-led programs, especially in the field of CBS and the in-service training of CHWs. The government, especially the Health and Social Development Departments, has steadily increased its support to non-profit organisations (NPOs) by addressing the health and development needs at community level through a cadre of community-based service providers (Mwita, 2010). This has in part been driven by HIV and AIDS, TB and maternal and child mortality, health conditions that form the bulk of the quadruple burden of public health diseases and concerns (Department of Health, 2013, p. 113). Thus although the need for more CHWs in South Africa is clear, Schneider, Hlophe and Van Rensburg (2008), say that “a lot more empirical evidence is required on national CHW programs, the problems they are facing and their contribution to addressing health needs, and the scaling up of new programs.” WHO (2007) state that: “CHWs can make a valuable contribution to community development and, more specifically, can improve access to and coverage of communities with basic health services. There is robust evidence that CHWs can undertake actions that lead to improved health outcomes.” It has however been identified that the very hierarchical and managerial functioning of the South African Health System did not immediately allow a clear task-shifting model to be implemented at facility-level (Cailhol, 2013, p. 10), which could be an obstacle to RCW workers programs in South Africa. Strategies such as task-shifting to staff with lower levels of clinical skills, and use of community health workers or expert patients, are likely to be important in enabling the health system to reach out to those struggling to obtain access to care (Goudge, Gilson, Russell, Gumede & Mills, 2009).

2.4 Community Health Workers: Western Cape

In 2010/2011 the Western Cape Province already had 2584 active CHBCs appointed via 145 non-profit organizations (NPOs), and the total community based services (CBS) patient contacts in

the Western Cape was 4.65 million (Western Cape Department of Health, 2011, p. 26). A large amount of the support has gone towards training, management, salaries and integration of cadres known generically in the Department of Health as Community Health Workers (CHW) and in the Department of Social Development as Community Care Givers (CCG) (Tshwane Department of Health and Social Services, 2009). Joint planning and collaboration, particularly aimed at supporting strategic HIV and AIDS goals, has been done by these two departments. This has been based on the specific need for various specialist cadres within HIV/AIDS, TB and maternal and child health programs as opposed to generic cadres across programs (Tshwane Department of Health and Social Services, 2009). During 2012 the Western Cape Department of Health embarked on a pilot project to up-skill some of the CHWs to become RCWs.

2.5 Up-skilling Community Health Workers in the Western Cape

The idea of a comprehensive RCW was first discussed with non-profit organization (NPO) stakeholders, and other service providers, at the Community Based Services (CBS) Summit held in Cape Town on 21 October 2011. It was an idea that had been under discussion for some time with the Western Cape Department of Health. According to Schneider (2012, p. 58), the rehabilitation care worker is essentially “being seen as someone that will be broadly trained *across* the different rehabilitation fields of physiotherapy, occupational therapy, speech therapy, as well as having basic counselling skills.” The RCW will be a *generic* rehabilitation worker and will have an ability to address a *range* of rehabilitation needs; with their skills being related to functional impairment rather than being related or ‘housed’ within a specific field or rehabilitation profession (Schneider, 2012, p. 58). They therefore do not yet fully achieve the mid-level worker status according to the definition provided above. The goal for the development of this new cadre of worker was twofold. *Firstly*, to provide a boost to the intermediate level of care, and secondly, to boost the community level of care, specifically with the intention that they would, in the future, form part of the envisaged ward-based team strategy (Schneider, 2012). Part of the vision of intermediate care facilities was that they would be “staffed by a multi-disciplinary team, with professional health workers working in collaboration with Carers and Rehabilitation Care Workers to provide patients with client-centred, quality care” (Schneider, Hlopie and van Rensburg, 2008, p. 58).

Task shifting⁷ of selected activities from health professionals to CHWs, mid-level workers and RCWs will require redefining the scope and practice of health professionals. Task shifting is an effective short term solution to improving access to health services (Dawad & Jobson, 2011). Task-shifting is a reality in Africa. It is common in Africa that MLWs perform duties that doctors should be doing and CHWs perform roles designed for MLWs (Mwita, 2010). There is a growing amount of evidence that “relatively lower qualified categories of staff can successfully perform a range of duties usually undertaken by health professionals based in formal institutions” (Dawad & Jobson, 2011, p. 1998). Dawad and Jobson (2011, p. 1997) argue that the use of “multi skilled mid-level workers who have undergone effective training programs in CBR, demonstrate that a wide range of rehabilitation activities can be effectively undertaken at a community level, and that this program provides an important example of how the WHO’s task-shifting guidelines for HIV treatment, care and prevention can be implemented.” Task-shifting could, therefore, provide care at a *level intermediate* to formal institutional care and HBC (Dawad and Jobson, 2011, p. 1998).

2.6 The National Development Plan: Positioning Community Health Workers

The Constitution of the Republic of South Africa Act No. 108 of 1996, in section 27(1) (a) obliges the DoH to provide citizens and residents in South Africa with access to health services. “The NDP charts a new path for South Africa and seeks to eliminate poverty and reduce inequality by 2030. The NDP identifies the following areas in the public health system for reform:

Firstly, more and better trained health professionals. (Department of Health Western Cape, 2013, p. 5). RCWs are not trained in depth as rehabilitation professionals, yet they have a broad skills mix and within appropriate systems could be more efficient in reaching a larger number of people with first level intervention.

Secondly, greater discretion over clinical and administrative matters at facility level, combined with effective accountability. (Department of Health Western Cape, 2013, p. 5). Healthcare 2030 specifies clearly that at the intermediate level of care, the RCWs will be supervised by

⁷ Task shifting – a review and subsequent delegation of tasks to the “lowest” category that can perform them successfully (Lehman and Saunders, 2007, p. 1).

rehabilitation professionals, but it does not specify who will be supervising them at the community level, thus indicating some uncertainty. According to Pinto (2012), one of the vital aspects of promoting an integrated and seamless service between levels of care [one of the objectives of Healthcare 2030], is a trans-disciplinary collaborative approach that must start at the level of service provider training. According to Pinto, (2012, p. e75), training should include collaboration between all the members of the health team, and value each member's specific input. Collaboration and training could be one of the key factors in enhancing the quality of supervision of RCWs (Schneider, Hlope and Van Rensburg, 2008, p. 186). However it is especially in resource poor environments and rural areas that experienced rehabilitation professionals are required for support and supervision (South African Committee of Health Science Deans, 2012, p. 21).

Thirdly, because of the RCWs skills in health prevention and promotion, their impact could promote the achievement of national health targets. Targets related especially to enhancing health and well-being are particularly relevant. These include; reducing incidences of chronic health conditions, enabling access to health care and the targets related to HIV, such as enabling a largely HIV free population of people under the age of 20 (Department of Health Western Cape, 2013, p. 6). Mayosi and Benatar (2014) are of the opinion that much of the hope for improving health services in the short term involves training a more appropriate balance of health care workers and refer frequently to the beneficial role that community health workers can play, especially in the rural areas.

2.7 Healthcare 2030: Re-engineering of the Workforce

The development of the 2030 Healthcare Plan (Department of Health Western Cape, 2013) is based on the successes of the 2010 Comprehensive Service Plan, and the 1995 Health Plan (Department of Health Western Cape, 2013, p. 11). One of the three major successes of these plans was the improvement in access to health care by expansion of the Community and Home Based Services within the District Health Services (Department of Health Western Cape, 2013, p. 11). The 2030 Health Plan has the improvement of the patient experience and quality of care at its core (Department of Health Western Cape, 2013). Seven guiding principles have been identified to guide the 2030 strategy. These are: patient-centred quality of care, a move towards an outcomes-based approach, the retention of a Primary Health Care (PHC) philosophy,

strengthening of the District Health Services Model, equity, affordability and building strategic partnerships (Department of Health Western Cape, 2013). The essential role of Rehabilitation Care Workers and Community Health Workers can be linked to all seven of these principles.

The third of eight priorities of the 'Human Resources for Health: Health Sector 2012/13 – 2016/17' is "*re-engineering of the workforce to meet service needs*" (Department of Health Western Cape, 2013, p. 5). The RCWs and their competencies are an innovation that fall within this strategy as their deployment increases the number of health staff with a broad approach offered at an affordable cost to the Department of Health. Cost effectiveness is essential, as the 2010 Comprehensive Service Plan (CSP) was dealt an unexpected blow to the fiscus by the Occupation Specific Dispensation (OSD), which increased the cost of staff to such an extent that it rendered the staffing numbers required for the CSP unaffordable (Western Cape Department of Health, 2013, p. 12).

2.8 Healthcare 2030: The Role of Community Health Workers

The quotation below is from Healthcare 2030, and is part of the *vision* pertaining to what community based care should look like by 2030. It details the role of CHWs as follows:

There is a full team of community health workers (CHWs). They have access to every household in the community. They are a direct link between the family, community and the health service and carry the message of healthy living to the people. They ensure that pregnant mothers attend the antenatal clinic, babies are immunized and patients take their medication regularly and correctly. They also provide health care advice on a range of issues including health prevention and promotion. Patients are referred to the clinic when necessary or managed at home. CHWs identify social problems and liaise with local social services, when necessary. CHWs live in the same area in which they work and have a good working relationship with the staff of their local clinic. CHWs will develop a solid relationship with each of the families they are responsible for and will form a critical bridge based on trust and empathy between the health service and families in the community (Western Cape Department of Health, 2013, p. 44).

In this vision there is a notable vagueness and absence regarding disability issues and rehabilitation. The clarification between what a CHW and a RCW does, is not spelt out. However

the focus of rehabilitation interventions in the CBS platform will be on the human functioning; activity limitations and participation restrictions. Intermediate care is designed to address recovery from a human functioning perspective and is more concerned with clinical recovery. HCBC expands on this focus by including strategies that support personal recovery; more specifically, the development of self-management strategies to mitigate the likelihood of secondary complication of an impairment (tertiary prevention); and the mobilization of agency at an individual, household and community level (health promotion) (Western Cape Department of Health, 2013, p. 43).

2.9 Training of Community Health Workers and Community Rehabilitation Workers

The World Health Report 2006 (WHO, 2006) indicated that the key element for successful health programs, in the context of severe health crises in developing countries, was well-trained health workers. This report recommended research into community health worker feasibility and effectiveness (WHO, 2006, p. 1). There are vast differences in roles and functions of community health workers within Africa and other developing countries, and the training length, approach and location also differs (WHO, 2006, p. 19). However, there appears to be agreement on one matter: that continuing or refresher training is as important as initial training (WHO, 2006, p. 19). The CBR Health Component (WHO, 2010), emphasizes health promotion, prevention, rehabilitation, assistive devices, and medical care. The fact that people with disabilities have a lower level of health than people without disabilities (Becker, 2006, p. 76S), supports the need for community health workers to be specifically trained to focus on the needs of people with disabilities.

The United Nations Convention on the Rights of Persons with Disabilities (CRPD) was passed in 2006 is a WHO initiative that provides direction and guidance to governments and relevant departments or stakeholders that engage or should engage with people with disabilities. This document has been ratified by the South African Government in 2007, obliging the upholding of these core values. Training institutions are thus obliged to train health and disability workers to fulfil this mandate.

Although the course reported on in this study is a totally new curriculum which includes a health care, rehabilitation and disability focus, it must be acknowledged that community rehabilitation

workers (CRWs) or community rehabilitation facilitators (CRFs) are not new in South Africa (Chappell & Johannsmeier, 2009, p. 7). Six of the nine provinces in South Africa have CRFs⁸. In their study Chappell and Johannsmeier (2009, p. 11), indicate that people with disabilities identify the outcomes of CRFs and CRWs as being related to not just medical rehabilitation, but aspects of community development, poverty reduction, social inclusion and equalisation of opportunities. Chappell and Johannsmeier (2009, p. 12) call for CRFs to be supported to work within a health and a community development context and recommend that WHO provide more guidance and policies regarding the training of mid-level workers. One study on how CRWs see their work, was found. This was by Petrick, Sichangwa, Collinson, and Pickford, (2002) and it focused mostly on how the CRWs perceived the amount of support they received. Despite a longstanding history of this cadre of worker in the country and elsewhere, limited studies on CHWs or CRFs perceptions of their training were found. An exception is the study done by Rule, (2013) which focussed on the training of CRFs in a specific CBR project in South Africa. It highlighted the need for training to be appropriate, finding that the students in the course were not adequately trained in empowerment approaches, even though the course was intended to have an emancipatory approach. Rule (2013) concluded by saying that follow-up research is needed, especially due to the complexity and multi-faceted nature of CBR.

2.10 The UCT RCW Training Program⁵

The pilot group of trained RCWs are community health workers with a rehabilitation and disability management focus which goes beyond just the *health component* of CBR. The current training program of the RCWs included modules on; Health Wellness and Functional Abilities (30 credits), Promoting Healthy Lifestyles (10 credits), Inclusive Development and Agency (15 credits), Disability Information, Management and Communication Systems (15 credits) and Work Integrated Practice Learning (50 credits). The expected outcome of each module is listed below:

Health Wellness and Functional Abilities: To understand human development and common health conditions in order to select and screen disabled clients for impairments and provide

⁸ Chappell and Johannsmeier (2009, p. 7) refer to the CRFs as mid-level workers, which is possibly correct. However, the RCWs may not be at the level of a mid-level worker at this stage, depending on which definition of mid-level worker is used, or the interpretation of the definition

basic interventions to improve participation in the life areas of living, learning, working and socialising. Principles and procedures related to caring for the carers would include the ability to work safely and prevent injury to self and others.

Promoting healthy lifestyles: To understand primary health care and assist in the design and implementation of health promotion actions, education and strategies in different contexts and life stages, namely, personal management, play, schooling, work, social interactions through sport etc.

Inclusive development and agency: To understand community based rehabilitation as a community development strategy to promote the rights of people with disabilities and implement strategies and actions to enable participation by taking environmental factors into consideration.

Disability information, management and communication systems: To describe and develop basic health information systems and implement management and communication systems in relation to care pathways of people with disabilities across sectors to be able to monitor inclusion and access to services.

Work integrated practice learning: To provide practice learning opportunities for students to integrate knowledge and skills related to the above courses. Practice the ability to screen, provide basic care, follow-up and referral systems, as it relates to the needs of people with disabilities.

The program was delivered from October 2012 to December 2013 at the site of the University of the Western Cape Community Project, Lentegur, in 4 course blocks, each spanning 2 to 3 weeks. The final Work Integrated Practice Learning (WIPL) course started from July 2013 for a period of 15 weeks. The WIPL course practical was given to the students at Life Esidemeni and Booth, intermediate care facilities in the Cape Town Metro. Input on aspects of disability practice, rehabilitation care and support were provided. Practice learning was also facilitated at various community based sites and facilities at district level in the Mitchell's Plain and Klipfontein substructures.

The different courses in this training program are thus directly related to the vital aspects of human functioning's [as included in the International Classification of Functioning (ICF)]; disability, health promotion, rehabilitation, social inclusion and poverty reduction, as indicated in the previous sub-section and Healthcare 2030 above.

2.11 Research design

A *qualitative descriptive research design* was used because it allows for a comprehensive summary of the RCWs perspectives of curriculum outcomes to emerge through discussion methods (Sandelowski, 2000). Fundamental qualitative description is more interpretive than quantitative description, (Sandelowski, 2000, p. 336). A qualitative descriptive study is especially suited to obtaining straight and minimally theorized answers to questions of special relevance to practitioners and policy makers (Sandelowski, 2000). It provides qualitatively rich explanations of the 'who', 'what' and 'how' of events and experiences.

In a recent literature review, Mannan et al., (2012) found that "focus groups, individual interviews, questionnaires and home visits, have been used to evaluate the effectiveness of community rehabilitation workers". "Focus groups have also been successfully used in the evaluation of curricula (Lie, Shapiro, Pardee, & Najm, 2008)". Qualitative methods in general, and focus groups in particular, are useful approaches when dealing with issues that involve opinions, needs, values and perceptions. They can "provide insights into those aspects of the curriculum that are not amenable to study using conventional methods" (Lie, et al., 2008, p. 2). Another advantage of the use of focus groups is that they provide "valuable insights into interim progress and most importantly, process" (Kevern & Webb, 2001, p. 324). The findings become available during, or immediately after, the group interaction due to the reflective nature of the inquiry. Focus groups also give participants more ownership of the data generation process, and limited the control of the researcher (Morrison-Beedy, Côté-Arsenault, & Feinstein, 2001) making this data collection method trustworthy and ethical. Focus groups allow for a larger number of participants to take part than could be achieved using individual interviews to answer the same research question. Furthermore they provided more stimuli for discussion and debate than individual interviews (Goodwin & Happell, 2009; Coenen, Stamm, Stucki, & Cieza, 2012). Group discussion allows the researchers to hear a range of opinions on the study question in a limited

period of time. No studies on the curricula or self-perceived outcomes of CBR worker training were found.

2.12 Summary

This literature review has indicated that community health workers, community rehabilitation workers, community rehab facilitators, disability facilitators and similar categories of staff are locally and internationally known to be effective agents in providing and promoting access to health care. The current health policies in the Western Cape indicate the importance of RCWs for the successful implementation of its health plans. The literature emphasizes the appropriateness of human resource planning by the national and provincial DoH in supporting the extension of the CHBC program with more specialist components such as those focussed on in this study. The research design which was selected was appropriate, according to the literature reviewed.

Chapter 3: Research Design

3.1 Introduction

In this chapter the researcher provides a step by step narrative of and rationale for the study methodology and methods, sampling and participants, as well as the processes and principles followed in generating, analysing and interpreting the data and ensuring ethical research standards, including informed consent of participants. The chapter concludes with comments on the suitability of the methodology and comments on logistical factors.

3.2 Situating the Researcher

The researcher is an occupational therapist working at the primary level of care, but in a different sub-district to the pilot project. As such he had nothing to do with the course, the supervision, placements or anything else related to the planning and execution of the pilot project. He has a long-standing interest in community-based rehabilitation, community-based health services, primary health care and occupational therapy services.

3.3 Research Context and Research Team

This research was initiated by the Division of Disability Studies at UCT and implemented at a community based site in Mitchell's Plain. At the time of the study, the RCWs were engaged in practical placements at Mitchell's Plain District Hospital⁹ and Conradie Care Center¹⁰. These placements were temporary placements, until their longer term placements were determined. They were also engaged in weekly contact sessions with training program facilitators for additional identified learning needs. The researcher and one co-facilitator facilitated the contact sessions on three of the days directly after these contact sessions.

3.4 Research Design

A qualitative research design was followed.

⁹ Mitchell's Plain District Hospital is a district hospital (level one hospital) located at Lentegour, Mitchell's Plain

¹⁰ Conradie Care Centre is an intermediate care facility, also located at Lentegour, Mitchell's Plain

3.4.1 Methodology

The qualitative research mandate is to “capture the complexity of the experiential and social world targeted for inquiry (Sandelowski & Leeman, 2012, p. 1410)”. Qualitative descriptive methodology enabled the researcher to elucidate the RCWs views about the outcomes obtained through the course in terms of self-perceived competencies, and not their actual competencies¹¹.

3.4.2 Method

Three focus groups, each comprised of six RCWs, of about an hour long were used to gather data. The choice of focus groups was reinforced by the literature. Chappell and Johannsmeier (2009), in their study on the impact of CBR by community rehabilitation facilitators, carried out focus groups, transect walks and interviews. These methods provided qualitative information and also provided an empowerment opportunity for the people with disabilities that were the participants in the study.

Besides the above advantages, an added value was the learning and reflection that occurred through the focus group process, which generated a rich understanding of the RCWs perspectives and enabled them to reflect more deeply on the outcomes by interacting with each other. Thus in this study, focus groups also had a joint purpose; firstly, to gather information, and secondly, to provide a reflective learning opportunity for the RCWs.

Disadvantages of focus groups include the fact that confidentiality and anonymity is problematic and that there can be domination by a small number of vocal participants (Goodwin and Happell, 2009). These were dealt with through signing confidentiality forms, providing relevant information to participants, regularly repeating the importance of confidentiality, skilled facilitation and the setting of clear group rules at the beginning of each session.

3.5 Study Participants

Thirty female RCWs completed the Higher Certificate in Disability Practice (Rehabilitation Care and Support). The following *inclusion criteria* were applied.

¹¹ A study of their actual competencies was carried out (Lufuluabo, 2013). This was a descriptive study through summative examination.

- participants attended eighty percent of the classes (determined by reviewing class attendance registers),
- had successfully completed the course (determined by reviewing final examination results), and
- had signed the consent form (determined by recording and documenting which potential participants had signed).

Five of the thirty RCWs did not sign the consent form (Table 2). One of the five who did not sign was off sick on the day of the recruitment and sadly this person passed away later in May 2014. Seven participants who signed the informed consent form were not requested to participate (Table 3), as three focus groups proved sufficient to obtain data saturation. A total of 18 RCWs participated in the three focus groups and 28 persons attended the feedback session. In order to have the three focus groups optimally representative of the participant pool, the participants were *stratified* according to the marks obtained in the module on Health, Wellness and Functional Ability and the NGOs they represented.

Table 1 on page 29 lists the participants, according to this stratification. Each of the focus groups were allocated two people who scored marks in the top third of the marks, two from the middle third and two from the lower third. Maximum variety of different NGOs [anonymized] were selected per group. This ensured that each group had maximum variety in terms of both marks achieved and experience before and during the course. The RCWs all knew each other well, having spent a large part of the year together on training. This was desired as it is a factor that promotes focus group discussion (Coenen, et al., 2012). The RCWs were not informed about the selection criteria, in order to prevent any self-comparison and identification.

Table 1. Stratification of the 18 RCWs who participated in the three focus groups based on course mark and representation of NGOs.¹²

Participants	NGO represented	Class attendance above 80%. (All attended more than 95% of coursework days.)	Signed the consent form	Final module work mark for HWFA ¹³ . (Even if they failed the course, they all passed the overall course)	Group 1	Group 2	Group 3
1	UWC	Yes	Yes	84	1		
2	AW	Yes	Yes	81	2		
3	AW	Yes	Yes	71		3	
4	SACLA	Yes	Yes	71		4	
5	OTS	Yes	Yes	66			5
6	AW	Yes	Yes	65			6
7	SACLA	Yes	Yes	59	7		
8	SACLA	Yes	Yes	59	8		
9	SACLA	Yes	Yes	58			9
10	AW	Yes	Yes	58		10	
11	PHILANI	Yes	Yes	57		11	
12	AW	Yes	Yes	57			12
13	SACLA	Yes	Yes	55	13		
14	PHILANI	Yes	Yes	54	14		
15	SACLA	Yes	Yes	53		15	
16	SACLA	Yes	Yes	50		16	
17	SACLA	Yes	Yes	48			17
18	SACLA	Yes	Yes	39			18

¹² Abbreviations for the NGOs are: UWC – University of the Western Cape Community Project; AW – Arisen Women; SACLA – South African Community Learning Association; OTS – Opportunities to Serve; PHILANI – Philani.

¹³ HWFA is the module called Health Wellness and Functional Ability

Table 2. RCWs who did not sign the consent form.

19	AW	Yes	No	68			
20	PHILANI	Yes	No	61			
21	SACLA	Yes	no	56			
22	AW	Yes	No	51			
23	SACLA	Yes	No	50			

Table 3. RCWs not required for participation in the focus groups.

24	AW	Yes	Yes	71			
25	AW	Yes	Yes	63			
26	SACLA	Yes	Yes	62			
27	PHILANI	Yes	Yes	57			
28	SACLA	Yes	Yes	56			
29	AW	Yes	Yes	56			
30	OTS	Yes	Yes	51			

3.6 Logistics, Structure and Process

Three focus groups were held on the 17th, 24th and 31st of May 2014 at the premises of the University of the Western Cape Community Rehabilitation Project at Lentegeur Hospital, Mitchell's Plain. As this venue was where the students did their contact and training sessions for the training course, they were very familiar with it and it was a non-threatening environment. The small venue facilitated intimate sharing and was private and quiet except for one day when renovations were being done on a neighbouring building. Due to this, the windows had to be shut on this day, but it did not influence proceedings, nor the quality of the sound recordings.

For the sake of logistical ease, the focus groups were run from 12h00 to 13h30, directly after contact sessions with the UCT lecturers. Refreshments were served and sufficient time was provided for a bathroom break before the start of the group sessions.

The researcher co-opted a co-facilitator, a qualified occupational therapist with extensive group facilitation skills. The same co-facilitator was present at all three focus groups and sat opposite the researcher in order to facilitate verbal or non-verbal communication between them during the session. Seating was arranged in a closed circle with a small table in the centre for the recording devices. After participants were seated, each participant was given a name tag with their preferred name for use in the group (usually their nickname or full first name). A number was also allocated to each participant and written on their nametag. The numbers were sequential. This made it easy for the co-facilitator to record what each person said, using the participant number and not their name. The co-facilitator kept a record of the proceedings in each focus group. At the start of each group she documented the names and positions of participants in her notes. The researcher began with introductions. The importance of confidentiality was highlighted and other logistical issues were dealt with. The researcher stated the aim of the research and explained briefly why the session was tape recorded and written notes taken. Thereafter the recording devices were switched on and the researcher proceeded with initiating discussions based on the open-ended questions (see Appendix 2). All the prepared questions were submitted to the groups. The same questions were posed to the different groups with slight variations in word use to improve understanding but maintaining the meaning of the questions. The lengths of the three focus group sessions were 1h07, 1h10 and 1h17 respectively.

The discussions were held in English. If participants struggled to express themselves, they were allowed to express aspects of their responses in their mother language (either Xhosa or Afrikaans) as long as someone else could understand and explain this to the other group members and the researcher. This only happened once and the participant was assisted by the group members until full clarity was achieved. Quiet group members were at times directly prompted for input and very talkative members were at times requested to give other members a chance to speak.

3.7 Data Management

Each focus group was recorded on two digital recorders to prevent loss of data through technical error. The files were downloaded onto the researcher's laptop and desktop computers and access was protected by a password. Data was erased from the recording devices as soon as it

was downloaded from them. Any hard copy document was safely stored either in a locked drawer at the researcher's home or work office. Two of the recordings were then transcribed verbatim by an independent person, and the third recording was transcribed by the researcher. This was because of time constraints on the transcribing. The co-facilitators notes were used to identify which participant, identified by number, said what.

3.8 Data Analysis and Interpretation

Within two days after each group the researcher listened to the recording and made notes. These notes provided a summary of what was discussed at each group. After the first and second group, the open ended questions were reviewed, and minor changes were made. The co-facilitator was also consulted when doing this. Thus, although the main questions were similar, slightly differing questions were submitted to the three different groups. This approach was used to promote discussion to the required depth, and to ensure that all aspects of the perceived benefits and challenges of the course were covered adequately.

Qualitative content analysis was used, as it is the best choice of analysis strategy for qualitative descriptive studies (Sandelowski, 2000). This involved a process of identifying, coding and categorizing the primary patterns in the data from the focus groups (Coenen, et al., 2012). Once the three sessions were completed, the researcher again listened to the recordings, and typed up a brief summary of the focus group, including what each participant said (referring to each person's number instead of name). The researcher analysed the data in three different ways, before settling on a method that best suited the data. The first attempt was done using data analysis method described by Hsieh & Shannon, (2005, p. 1277). Analysis involved coding each focus group individually; deciphering sub-categories, compiling categories, identifying themes that emerged, and then amalgamating the themes into a plot. The second was an attempt to analyse the three groups together grouping the data according to the questions asked. The third and most efficient way was to print out the codes, cut out each one and then find its 'place' in preliminary sub categories, categories and themes on two sheets of newsprint. The two sheets were then amalgamated onto one sheet, in order to provide a comprehensive yet manageable bird's eye view of the data (see Appendix 4).

Once analysed the emerging subcategories, categories, themes and plot were presented to the groups in a member checking session that was held on 24 November 2014 with all participants and other RCWs who did not attend the focus groups¹⁴. During this session the researcher gave feedback on the findings. The plot, each theme, category and sub category were presented and explained to participants. Comments from the RCWs were requested and where indicated, incorporated into the findings to ensure that the content was correct in terms of facts and implied meaning.

3.9 Research Rigour

To promote richness of discussion from their potentially different experiences purposive sampling was used [see Table 1 on page 29]. Because of this however, it cannot be assumed that the views of participants are representative of the entire class, even though the majority of the class participated. The time for data collection was appropriate as the RCWs had recently completed the course in December 2013. They were still involved in trial placements and were engaged in ongoing academic activities. UCT had been granted an additional contract for continued input to the RCWs. The data was gathered from participants during this 3 month long period during which the students had contact on a weekly basis with UCT staff for ongoing in-service training. They were also engaged in practical work placements at Mitchell's Plain District Hospital at the time. The trustworthiness of the data analysis and interpretation process was ensured by adhering to the principles of credibility, transferability, dependability and confirmability.

3.9.1 Credibility

Interviews from the three focus groups were transcribed verbatim. After the analysis stage, member checking was done with all participants as well as the RCWs who did not participate in the focus groups.

¹⁴ Non-participants were included, firstly, to demonstrate non partiality to those who did not sign the consent form, secondly, to demonstrate transparency to all the RCWs, and thirdly, to potentially get more people's views.

3.9.2 Transferability

The questions used in the focus groups are contained in Appendix 2. Standard procedures for running focus groups were maintained and this chapter contains a detailed explanation of the process followed and can therefore be replicated in another study.

3.9.3 Dependability

Direct anonymised quotations, as well as comprehensive descriptions of the data, were done. The questions or statements used by the researcher in the focus groups are available [see Appendix 2]. Furthermore, rigor in the process was maintained by verbatim transcription.

3.9.4 Confirmability

Member checking was done during a follow up session with all participants and RCWs who did not participate. Reflexivity was part of the process, by the researcher being aware of his own assumptions, using open-ended questions and responding to pertinent issues raised.

3.10 Research Ethics

Approval for this study was obtained from the UCT Faculty of Health Sciences Human Research Ethics Committee (see Appendix 3) with reference number 088\2014. This study did adhere to the Declaration of Helsinki (WHO, 2013).

3.10.1 Informed Consent

On the 5th of May 2014, the group of potential participants were addressed by the researcher during one of their contact sessions with UCT staff. The purpose of the study and requirements of the participants was explained. An information letter (see Appendix 5) regarding informed consent and the consent letter (see Appendix 6) itself were provided for them to read. A letter regarding confidentiality was also provided, (see Appendix 7). They were requested to sign the consent form and the confidentiality form should they choose to participate. The whole group were requested to fold their forms in half and pass them to the front. This was in order to ensure anonymity as to who did and did not sign the consent forms. The researcher therefore only found out after the session whether the forms had been signed or not. Participants were given the information letter to keep.

3.10.2 Autonomy

Participants were informed verbally and in a detailed information letter about the study a few weeks in advance. The information letter was provided in the language of their choice (English, Afrikaans or Xhosa) and they were provided with ample time to read it and ask questions. Participation was voluntary. Only then were volunteers requested to sign the informed consent forms and the confidentiality clause (see Appendices 5, 6, 7), agreeing to participate in all processes of the research as well as agree to confidentiality. Thus, voluntary participation with informed consent was adhered to and participants were free to withdraw at any stage.

3.10.3 Beneficence

The relevant benefits of the research were passed on to participants. The findings were made available to them through the feedback session. Two specific areas of need were voiced by participants. One was a request for more training regarding management of people who are blind and/or deaf. The second was more input on resource mapping. These two needs were communicated to the UCT course conveners.

3.10.4 Non-maleficence

The facilitators valued all input given by the participants. Clinical reasoning and therapeutic skills were used to determine when deeper probing was required and when to offer support to participants who became teary or emotionally distressed. No one presented with emotional or other needs that required referral for further management.

3.10.5 Confidentiality

This is a particular weakness of the focus group data collection strategy (Kevern and Web, 2001). Some aspects of the confidentiality are out of the researcher's control, such as what the participants discuss after a group session has taken place. Signing of a confidentiality agreement letter was required by all participants and facilitators. Confidentiality was explained to participants in detail, with an opportunity for questions. Confidentiality was also verbally agreed on at the beginning of each focus group. Group rules of respect and allowing everyone a chance to speak were discussed at the beginning of each group as well.

3.10.6 Justice

All the participants were given the opportunity to benefit from additional training inputs should this opportunity arise out of recommendations from this research. All participants would benefit equally because the requests were treated anonymously. The requests for additional training were given to the Division of Disability Studies convener and the completed dissertation will be provided to them on completion.

3.10.7 Risks and Referral Benefits for Participants

There were no known risks associated with participation. No circumstances arose whereby any form of debriefing, counselling or other form of social or medical intervention was identified for any of the participants. Thus no such referrals were considered.

3.10.8 Freedom of Expression

Care was taken to protect participants' freedom of expression and to ensure that they were not intimidated or made to feel uncomfortable to express their opinions. A conscious effort was therefore made to treat all participants with respect, by demonstrating good listening skills and refraining from a pedantic or patronizing attitude.

3.11 Summary

This chapter has provided details about the choice of qualitative descriptive research methodology, providing evidence of why the choice was made as well as its benefits and limitations. It provides specific details about how research rigor, data collection, data analysis and ethical procedures were carried out. The methodological approaches followed in this research study were adhered to in sufficient detail for trustworthy and ethical research. No logistical factors negatively influenced the research. The following chapter describes all the findings as obtained from the data.

Chapter 4: Findings

4.1 Introduction

The findings are represented diagrammatically and through a rich description of the input given by the participants. Starting with the plot, the evidence of the findings is presented in terms of two themes which serve to substantiate the categories and sub-categories of each. These themes uncover how the findings demonstrate the outcomes of a pilot RCW training program from the perspective of new graduates of the pilot training program.

4.2 The Plot: 'Baanbrekers'/Pioneers

The concept of 'plot' refers to the main storyline or overarching message that unites the themes of a story. It weaves like a thread throughout a series of events that make up a story. In this instance the narrative of the CHWs who participated in a new course, equipping them to become RCWs centred on the plot of '*baanbrekers*'/pioneers. They perceived themselves as pioneering new ways of providing basic health services at primary level. This was evident from the way they spoke about moving the health service to a new level, acquiring a new skills set, making a broad impact and managing personal and work changes. They identified needs in new ways, discovered new personal characteristics and worked in new ways as part of the health team and in the community. The plot captures the determination of the participants to portray their achievements and struggles in forging their own track of breaking new ground. In some ways it was a new 'space', / 'practice territory', or ground in the health field. They could identify this "*baan*" / "new ground" in terms of practice space, as well as the impact of their acquired competencies on the services offered by themselves and others on behalf of the WCDoH. They recognized that they, as a new cadre of worker, were making history and that this was something new for the WCDoH.

The metaphor of being pioneers in a new field of work or new skills sets, assists in understanding the RCWs frame of reference. The plot can be viewed from different angles, each theme providing a different facet of the RCWs progression towards an enhanced knowledge and skill set, based on participation in the '*baanbreker*' (pioneering) curriculum. The '*baanbreker*'/pioneering plot integrates the two themes that emerged; firstly, "*Moving health services to a new level*", and secondly, "*We manage change in new ways*." The first theme

comprised two categories: firstly, ‘*A new skills mix in one person*’ and secondly, ‘*One person making a new broad impact*’. The second theme also comprised two categories: ‘*Changing the way I was before*’ and ‘*Changing the way I work*’. Diagram 1 depicts the composition of the plot through two themes and four categories. Diagrams 2 and 3 elaborate on each of the two themes.

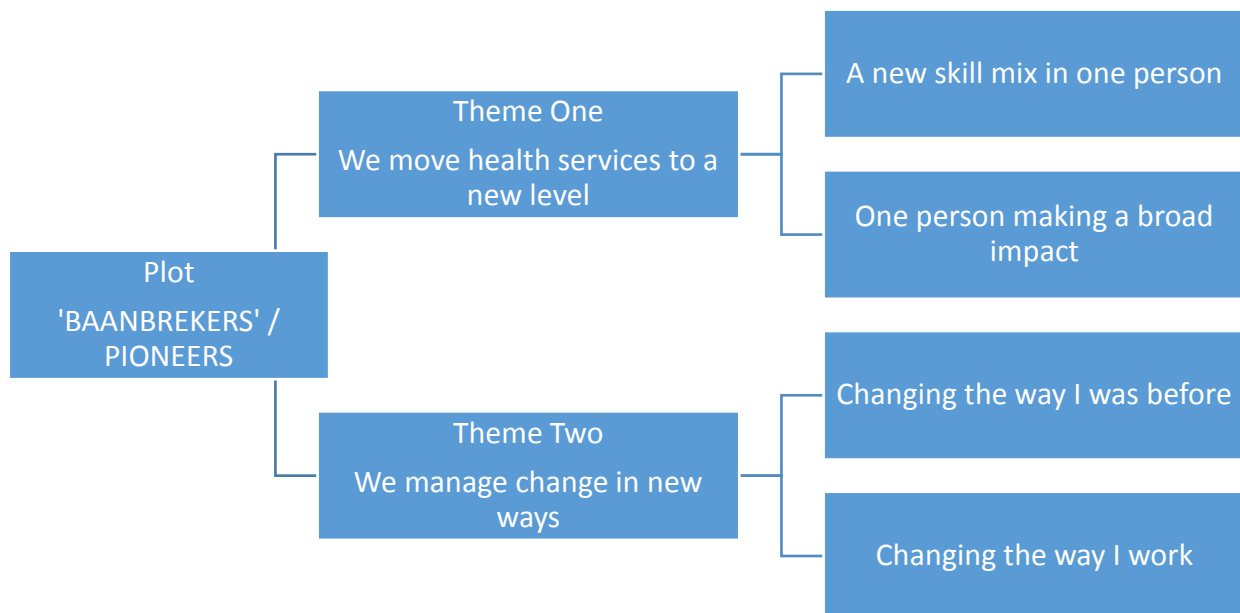
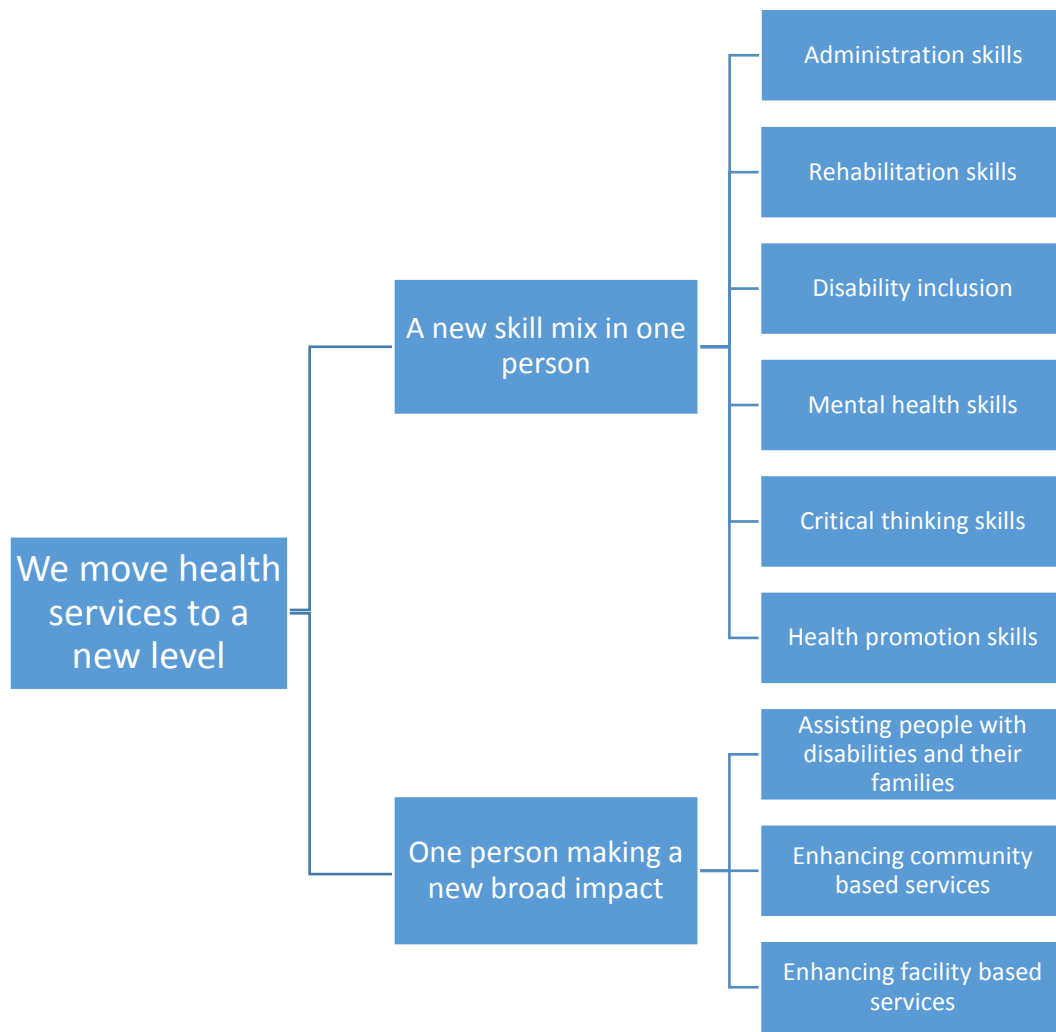


Diagram 1: The Composition of the Plot

4.3 Theme One: ‘We Move Health Services to a New level’

The first theme illustrates the means (*the ‘what’*) through which pioneering unfolded. It is comprised of two categories: ‘*a new skills mix in one person*’ (six sub-categories) and ‘*one person making a new broad impact*’ (three sub-categories). Diagram 2 depicts the composition of the first theme “*We move health services to a new level*”.

Diagram 2: The Composition of Theme One



Theme one tells the story, from the perspective of the RCWs, of what the course accomplished through the creation of a new category of worker. This accomplishment is marked by unique skill mixes in each individual worker. The findings indicate that the RCWs were positioned to enhance access to health services by the direct and indirect ways in which they were equipped with a new skills set to positively influence the health of their communities. People were screened and assisted through appropriate (for their level of training) rehabilitative, disability management and therapeutic measures in their homes and communities because the RCWs were trained in

early identification of health and disability needs. The level of training they receive still requires them to work under supervision of rehabilitation professionals.

“...we [are] like soldiers that got the weapon that they always looking for, so now we put the weapon, so we bring everything together” [Group 3, p. 5].

The contribution of the course to the skill mix of the RCWs was, according to their interpretation of their impact, a huge move forward for the health service in their community. It built on the foundations of their existing skills base, the foundations of which were laid by the home based courses that they had attended prior to the RCW training.

“The home based care course was like the foundation, the RCW course was like the bricks” [Group 2, p. 2].

This statement indicates three things. Firstly, the high value the RCWs ascribed to the initial solid foundation of the CHBC training. Secondly, the limitations of the CHBC training. Thirdly, it indicates how they valued the many new skills (bricks) that the RCW training program added to their skills mix.

4.3.1 Category One: ‘A New Skills Mix in One Person’

The category for the new set of skills that they identified was grouped into six sub-categories, each containing a particular/unique skill set. This set of six sub-categories is the largest data set, which highlights the extent of the new skill mix assimilated by the RCWs throughout the course. Some of the skills which the RCWs attributed to the course are quite new or present in limited numbers within the WCDoh. The pioneering dimension of this skills set, arising from a combination of rehabilitation profession foundational skills, was the uniqueness of it being present in one community worker. The following six sub-categories of skills are presented in the next section: administration, rehabilitation, disability inclusion, mental health, critical thinking and health promotion.

Administration Skills: It was easy to detect administration as a competency because numerous participants mentioned it as a new strength. Most of the data related to medical recordkeeping.

“It’s important to write everything you’ve done. For me, before I was just writing the patient’s name, I didn’t, I was ignoring the diagnosis of the patient. So now I know you

must write, you must know exactly what happened, what's wrong of...of [with] this patient, what causes, you must know what happened, what is the cause, what to, ...you must know even what date this time he was involved in car accident, so what treatment must I do for this patient..." [Group 1, p. 4].

In addition, they were able to critique other professions for the absence of appropriate medical records, or lack of updated records and they were able to correct mistakes they found in patients folders. They perceived themselves as able to use patients medical files appropriately, write accurate medical notes, and generally contribute to quality of recordkeeping in the hospitals.

"when we at the (institution x) we have to um draw information from the files and, and I think they file system wasn't like at (institution y) cos there we got everything like organized, but (institution x) was different um we have to seek, it's not organized so you have to find information here and there and to get the message...it isn't always easy to get information but it's important to get the correct information". And "while I was in (institution z) I used to take the folders and put on a correct way accurately. I can see the first document is for the doctors and other stuff, and other stuff is upside down. I just make it a point that they can see that I know what I am doing. I put on it correct. They say "hey Pumla¹⁵ you've got nothing to do", no I just want to show you guys that how you do this is because this is very important to, to, document the, on a correct way, the folders" [Group 1, p. 4].

The new skill in administration skills therefore assisted them in their work, providing more accuracy and objectivity, which in turn led to greater clarity and focus in their other responsibilities such as rehabilitation.

Rehabilitation Skills: The codes clearly identify skills obtained for treating people in the rehabilitation phase, who have specific conditions such as paraplegia, stroke, and cerebral palsy. The majority of the codes focused on facilitation of functioning in activities of daily living (ADLs). There was evidence of a clear shift in approach from doing things for the person, to facilitating independence.

¹⁵ Pseudonym used for the sake of confidentiality

“...because in home based care the, the people, the clients, are very dependent of you, but in rehab you are making that person independent to that he can do things for himself ... we used to um to get the client out of bed and just um, get the water and wash the client, but now you must know, no, put the little basin, if he had a stroke on that side, [demonstrating] that he can stretch and wash, and, and just, you know and wash his face and so he has to do it himself now” [Group 1, p. 6].

“Can I also say that even for myself I have been in the rehab before I did the course, but for me the importance of the exercises, because we did the exercises but we didn’t do it the correct way and we didn’t know, uhmmm, When, when, when, the physio’s speak, they speak about adduction and abduction and you are thinking- okaaay- but you are not really sure what it means. But now you, you, you are able to identify that name with what you are meant to do and also to explain to the client the importance of the exercises, what the benefits of the exercises are what it can do for you. So for me it is, it, it, yes it has been very beneficial not just in the exercise, ... and um also (cough) excuse me, with the resources within your community you, you find people with a variety of disability in one house. So now you can identify, oh this is, this I know where I can refer this person to, or I know what to do in this case. So it has really been beneficial to me” [Group 1, p. 1].

The newfound knowledge and skills have a clear rehabilitation impetus. However, a distinct skill namely disability inclusion, that is different from rehabilitation, was also evident.

Disability Inclusion: A disability inclusion skill set was noticeably strong in their work. It was also a notably new understanding to them, something they previously had not had. The insight into the need for people with disabilities to be respected and included into society and acknowledged as people with equal rights was clearly evident in the discussions. A case was mentioned that describes this:

“for instance there’s a small boytjie [little boy] there by us in the area he’s got a disability he’s limping and then he they call him hoppie [hoppy] and you know children’s mindset was also changed cos they used to call him hoppie the whole time then I said why you call him hoppie, they said ja cos he hop the whole time. So I said no he’s got a beautiful name and they all started to call him now Jayden, on his on his um name and um I said

why you call him hoppie he's got a beautiful name just see how and sometime now sometimes it also the negligence of the parents cos they also don't clean the children properly then the children look so dirty and all look down on this child so I took him from the street and I cleaned him I washed him and I dressed him nicely from sommer from my daughters clothes was like a unisex stuff then I dressed him up and I let him go out they said "jo hoppie jy lyk um kwaai " so I said here we as the as the rehab workers also had to give an input in the children or the communities' life so they can also see the change and um so also um this how do you call it now um this stigma that break the stigma" [Group 2, p. 3].

They felt that the course equipped them, amongst other skills, to promote the right to self-determination of people with disabilities (PWD) and to raise awareness at community level about the negative stigmas of disability. Another example illustrates the point clearly:

"...yes, it's very important in the community because during Friday Passover this year un l, l, l, took two guys who is in wheelchairs for Sunday School something like 12 years and 16 years for Sunday School and he's playing a role in um play. I ask my cousins brother to took these two in my church to play the role play for Jesus Christ at the cross something like that. One of these guys is Jesus Christ in the cross sitting on the wheelchair. All the people in the church was so surprised of that guy so I just include this guy to [go with] the normal child" [Group 1, p. 11].

The above quotes illustrate their ability to understand disability in a new way. In addition to this, the ability to manage and assist people with mental illness became evident.

Mental Health Skills: These skills relate mostly to the way they perceived themselves as able to identify mental health problems and handle people with difficult behaviours. They found themselves no longer afraid, and able to calm people down who were aggressive or upset.

"Mr. R, he was in charge of the trauma unit, he was amazed by the way that we were able to interact with people that have mental disabilities, the way that we carried ourselves, like he said, they [the staff] don't know what, what we were about. We were able to, uhm, remain calm when they [the patients] had a violent outburst, we were able to speak to them and calm them down, and put them where they need to be. We were

able to get them to put on the brown gown, hey, when they asked us why do we have this colour, and someone else, [another colour]. We were able to communicate with them and keep them calm, and, jah, that's what he (Mr. R.) saw" [Group 3, p. 6].

"... but in different, like the disability - intellectual disability, because it is a bit um or mental disability it is a bit scary. Before you don't wanna, you don't wanna have clients that have that. But now it, it, you, you more comfort, I think comfortable ..." [Group 1, p. 2].

On a few occasions during the focus groups the RCWs reflected on how the new knowledge and skills enabled them to identify problems related to mental illness within their family. They could make a meaningful difference in certain family circumstances, and understand these types of problems in a new light.

Critical Thinking Skills: The data indicated new skill development in critical thinking. This new way of reasoning influenced their ability to adapt to the various interpersonal situations in which they found themselves; approaching problems differently, and enabling them to have confidence even in challenging social circumstances.

"You know it changed a lot in our minds. We are quick thinkers now, we don't only think of something that we see, when someone is speaking we also observe and listen. And we say; do you have the reasons to do that... and the person started to change" [Group 3, p. 14].

"We actually warned the doctor about the wrong folder, the doctor took blood from the wrong patient, and prepared the wrong person for surgery. We stopped it right then and there, and they asked us: 'how could, you are all over the show', so we said: 'that is it', we are taught to observe, our minds are not just here, it's all over the place" [Group 3, p. 4].

The following excerpt from a focus group conversation highlights two important aspects. Firstly, a level of insight into interpersonal communication, and secondly, clinical reasoning, vital to this cadre of worker concerning not going beyond their scope of practice.

"I didn't know the, if someone would ...ah [for example] grief, how to handle that patient. But now I've got some basic ah, counselling skills. Now I know the

communication is very important. I know now if there is any conflict in the family I know how to identify the, the, the, what is the cause of the conflict now. All those that I'm getting from school¹⁶" [Group 1, p. 7].

Researcher: "Do you agree? That you've got counselling skills?" [Group 1, p. 7].

p4: "yes" [Group 1, p. 7].

p1: "Yes we did, but I think was what important also for me to learn is when we cannot do everything. When we can't or we don't know we don't know. We cannot like suck them things out of our thumbs and say this is what. No, you have to, we have to know when to refer and where to draw the line so for me that was important as well" [Group 1, p. 7].

It was clear that the training provided sufficient new knowledge and skills to have a broader perspective on health and disability issues. The last quote by person 1 provides some reassurance that RCWs understand their limitations, as it appeared that some RCWs were taking their new knowledge and skills beyond their expected scope.

Health Promotion Skills: Their understanding of determinants of health together with new knowledge of health conditions enabled the RCWs to participate in health promotion activities in new and different ways. They saw it as their role to motivate people to change unhealthy behaviours and manage their health conditions properly.

"For me [the most helpful part of the course] was health promotion because when we are there we do education about how to wash the hands from the patient and also to cut their nails. I'm so glad because when we come there they've got the nail cutters at 'Beaconvale'¹⁷ and when we going there at hospital I'm asking the nurse from the nail cutter to cut the nails of the patient but they said no they don't have they don't have anything you see. Even at my community now from the people who live in shack they throw water there in street. I talk to them to, to help to dig a hole to take out the water and dirty things, and also educate them about TB to open the windows every day in the

¹⁶ The participant used the word 'school' to refer to the pilot training program

¹⁷ A community based training site

morning and afternoon, and eat lots of vegetables and some of them they say they did not have a space to plant. I assist them and tell them they even can take the old tires and basin and put them next to the door and plant their vegetables...” [Group 3, p. 11].”

“...like for instance in terms of preventing, preventing and promotion, if we met the diabetic person, and this person says; I eat a lot of uuh, like I was in Town Centre, and I get fish and chips there, or I get Kentucky, now I’m feeling my face is feeling like swollen, so we know what to say there, we know you are not supposed to eat a lot of salty things because you are diabetic and also hypertension, so there are things you not supposed to eat. That is why you face is so swollen, you can mah go to the day hospital quickly before anything happens, so we know what to say to the client” [Group 3, p. 1].

The confidence of the RCWs to address the above types of issues is important to note. The fact that they actually applied the theory of health promotion could indicate that the course achieved the goals of not just providing knowledge to the participants, but practice skills as well.

4.3.2 Category Two: ‘One Person Making a New Broad Impact’

The ‘all-in-one-worker’ concept was articulated by the RCWs. On the one hand they acquired a variety of skills, and on the other hand they became one person capable of doing them all. They felt unique, proud, independent and able to do much more than before. They felt a sense of personal achievement and able to achieve a variety of tasks.

“I’m doing everything because of this course, and I’m not afraid because I know what I did [learnt in the course]” [Group 1, p. 1].

“..Because before, when I come to visit the houses, I see different illnesses like, ahh, the person can’t talk. We didn’t know, even look at the person because we don’t know how we are going to help that patient. And also the mental illnesses, we didn’t even look at that because we are just, get frightened; how are you going to help that person. So we just don’t look, but um, we don’t help the family of that, but now we know the resources where can you transfer the, a family, you you educate the the families about that client” [Group 1, p. 2].

Category Two consisted of three sub categories which will be substantiated in the following section. They are: 'assisting people with disabilities and their families', 'enhancing community based services', and 'enhancing facility based services'.

Assisting People with Disabilities and Their Families: The RCWs identified the need to consider the client as the central focus of their health interventions, but in addition, the data indicates a strong focus on involving family role-players in the client's treatment. Although the ward based teams are not established, it is possible that the RCWs are already able to fulfil some of the roles and tasks that these teams eventually will be doing.

"there was a challenge with a social problem within a home. We, I, actually had to explain to the family what the Parkinson's disease is and how it affects the person's health, you know sitting with the aches and pains and then the husband still comes with his abusive manner, and what it does to her ... but I also explained to the patient how he feels because she has no independence, he doesn't see her as a woman anymore, he just sees her as someone that he has to do things for. So I actually had to tell her, how about telling him your worth, that you are still the woman you used to be, so that he can start seeing you as a woman and not as, uhm, how do you put it now, ... not as someone that is, ... what did he say ... his words was ... I'm frustrated with her because why ... it's like she's taking her disability out on us..... and that is actually the first time that he said that to her. And then her mother came forward as well saying that ... I feel so surprised because why, she and her family... I want to live in peace and they constantly fighting. And then we saw where the root of the problem was. And I would explain to the husband on another, not in front of her... you know what would happen to you if someone else comes into your home and has to listen to you having violent outbursts with your wife. You could go to prison for that because it's not just assaulting, it's not just domestic violence issue, she is disabled as well. And when I told him that, you know you want to add this to her but you don't know what she's dealing with on a daily basis. She's the one that has to deal with the disability, she is the one sitting with the aches and pains, and she's the one that's sitting with the emotion of not being able to be the woman that she used to be for you. And I told him even if you feel frustrated take a walk, it will be better for you. And then I got my supervisor in and that's how we dealt with the problem and actually she reported to me that there is a social worker going in now, and uhm, what

you call it now, uhm, the community leader as well helping with the social problem”
[Group 3, p. 7].

The integration of various domains of practice come into play in the above quotation. An understanding of disability, mental health skills, and critical thinking skills are evident here. This indicates that the modules of the course were presented in an integrated fashion.

Enhancing Community Based Services: Although RCWs worked effectively at institution/facility level, their uniqueness and skills were most evident at community level – within people’s homes and within societal life. RCWs reported that their clients felt better prepared for discharge after interactions with RCWs. Although most health professions include family members in the planning and management of health interventions, it was emphasized that access to family members for assessing and training is far easier at home. More realistic interventions can be provided when the home circumstances are known. They were able to identify the effects of stigma, and became community developers by being role models through problem identification and resolution. In particular, they perceived themselves as being equipped to influence mindset change in community members.

“For instance this girlie she’s a Down Syndrome girl and then she used to stand by the windows the whole time cos she’s got nothing to keep her busy. Then they call “haai see there for platgefrijie [flat face]” then I’ll say, “what are you saying there?,” then some of the parents they get offended cos of the names the names these kids are being called and then I started chatting with them and now having like group sessions where they like um do sketches what they used to do at the school they like do paintings and they they, ah, ah, write children’s names on it and they like sell it in the community for, um like for fundraising for them cos [because] they mos [of course] like only get the disability [disability grant] to to, um keep them financially busy so um support them financially but now they also sell these small itempies [items] that they making like cords and stuff then they sell it and they get more income [Group 2, p. 14].”

“...on a daily basis we are using like, um, we are so many things in one, on a daily basis, especially going into community, because we are doing counselling, we are doing uhm, rehabilitation where we are giving them exercise, we are doing nursing work by

observing their vital signs, and giving them a bed bath or whatever, um, yah, it's so many things in one [Group 3, p. 6]."

With regards the important CBS role of early detection and referral, the data indicated that RCWs believed they were not only competent, but also confident to refer. The RCWs, when managing clients in their homes, reported that they are aware of the need to assess holistically, and identify issues before they become problems, not only of the client, but of also of other issues in the home or community:

"For instance there's a child in my street I notice one day I, I, I've seen him but it [the child] was crying and it was hot and I told myself there should be something wrong with that boy because I mean a 3 year old boy can't just keep on crying without saying what makes him cry. So I ask him if he can, I ask if he can, can, talk... ah [no response], I just ask one, one of the ah the young ones, they said no he can't, and I knew that, ja, I couldn't notice um notice [before], that [the child has a problem] ja [yes] so ja it has helped me a lot [Group 2, p. 2]!"

The significance of this quote is that it indicates a very appropriate observation skill which was developed on the course. Its link to a child with developmental delay is also significant because prior to this course, the RCWs were not trained in skills related to early childhood development.

Enhancing Facility Based Services: The RCWs found they could contribute in new ways at the facilities where they did their practical placements. The excerpt below portrays the extent to which the RCWs had insight into patient's situations, needs and potential. The excerpt details an interaction with a paraplegic patient and is an indication of how workers were able to contribute. The RCW training appears to have enabled them to look beyond what was written or not written in this patient's folder. They used initiative, to the patient's advantage.

"I ask what is wrong with him and then he told me "no Sister I can't walk" with that attitude and I said to him. No man what do you can talk you can't walk but I notice it because the monkey bar was on top of him and I said "reach out your hand and touch the monkey bar "he said what's a monkey bar. I'm not a monkey! Then you, I have to explain to him it's not a monkey, monkey in a tree. We call it a monkey bar because it's for him to strengthen his upper body. He said I was lying and I wonder what thing is this.

You see even the nurses or the physio's, they don't explain to the patient why they use that equipment. If somebody bring a ball I never seen a ball in my life I make an example and I put it in front of me I would now know what must I do with it I will just stare at it and ignore it cos I don't know it's something you can pick up or kick it's the same with a paraplegic if you don't explain to him what you gonna do, why it is there... And I said to him come, come, come I'm not gonna help you take you hand and bring yourself up. Which he did and he said "jo sister" and I said yes. Because of the wound they didn't... He's' been there 3 months they didn't give him any physio they only do the wounds and that is that. You have to see to the other needs of the patient also they know because in the folder everything is written up, but the doctor write; do the wounds that they overlook the other parts. And he said "jo sister I feel lekker, come make more". And I said no come, come, come use it and he said at first "I can't" I said no, no. You have to read between the lines because the patient can play you as well because they get away for so long you have to be firm, strict and firm, but gentle and the best part of it when he come Monday he said: "sister it's the first time in my life I went out of this hospital I ask him "where were you?". To Wellington to his sister his sister is a staff nurse but still she don't even have the time to do the exercises ..." [Group 2, p. 4].

The following extract indicates one participant's contributions at an institution for children:

"When I went to um St. Josephs now I had a child and I just look at the child this child looks so small I wonder now what is this child's age and then I could see that she's got ah ah developmental delay cos she's now 21 months and she's still sliding on her butt, she's not crawling or she's not standing up and now I could go back to the developmental um stages and I could help her get into the real the right um developmental um stages to go like she had to like crawl before she can stand up and um I even um help her cos she's got a, a problem with her one hand I could even help her with her hand whenever she like crawl I just lift up the hand that she can put the weight on the hand where we normally would like just ignore the child" [Group 2, p. 5].

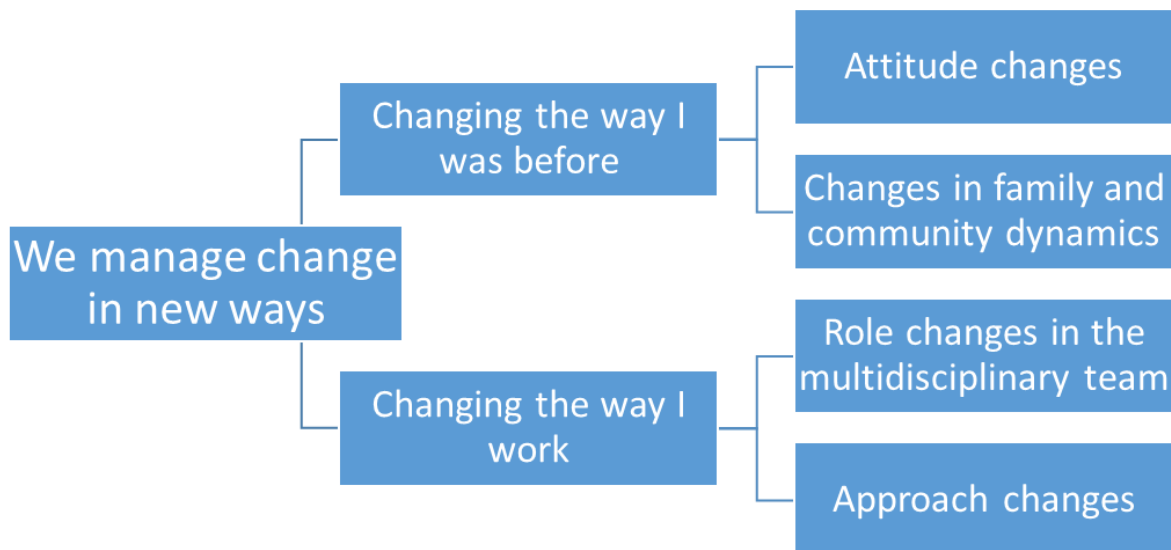
Shifts in confidence, in the ability to put a very new skill into practice, and in an understanding of developmental stages is evident in this quotation. Before doing the training, they did not treat

children. The RCWs are therefore able to demonstrate a greater versatility in terms of where and how they supplement the health services.

4.4 Theme Two: 'We Manage Change in New Ways'

The second theme illustrates 'how' the 'baanbreker' plot materialized, i.e. the process through which pioneering unfolded as a consequence or outcome of the RCW training. It captures some of the personal/workplace tensions faced including the systemic dynamics that had to be dealt with in the process of breaking the new health service delivery ground. The second theme comprised two categories: *Changing the Way I Was Before*, (two sub-categories) and *Changing the Way I Work*, (two sub-categories). Diagram 3 depicts the composition of the second theme "we manage change in new ways".

Diagram 3: The Composition of Theme Two



Theme two emerged from the categories and subcategories that portrayed the positive and negative ways that the RCWs had to process change in the context of their personal, social and work lives. It describes shifts and changes emanating from the RCW training that altered their experience and performance of various roles. The training triggered changes as they assimilated the new competencies into their lives whether at home, in the community, or in the various

institutions they worked in. Although the training produced by far mostly positive achievements, there were certain things in the training, or that resulted from the training, that caused hardships or challenges. The data revealed ‘how’ they succeeded to impress their own families, professionals, managers, clients, communities and even themselves. They were able to fill a gap, meet a need, and make a difference in the various practice-learning placements that formed part of the course. The RCWs own lives, families and communities were impacted by the transfer of skills and health information as well as enhancing helpful attitudes to a category of staff that are working at grass roots levels.

“So I remember we tell the sister that there was a small boy of 12 years so because we are in the ward with the patient, we chat with the boy, and then we, we get the information from him that he stay alone at his home. So we tell the sister that sister, we, you can call the social worker for this child because there is a problem back in, in, in, his home. So the sister was amazed where we get this information. So we tell them that our role is to talk with patient, see what you can do for a patient because some of them they don’t talk but they have got problem back home” [Group 3, p. 3].

Community members found the RCWs to be useful resources to come and ask for help, and even family members contacted them for their newly acquired skills. The two categories, i.e. *changing the way I was before* and *changing the way I work*, are hereby justified.

4.4.1 Category One: ‘Changing the Way I Was Before’

During the process of the course, the RCWs grew in insight about themselves. This led to changes in their functioning in their own homes and environments. They had to adjust to changes in expectations placed on them by family and community members. A participant blurted out:

“We found new skills in ourselves, and that was exciting!” [Group 3, p. 14].

“I’m more equipped than before I was, so it helped me a lot in changing the way I was before, now I can work in everywhere, even if my family one of my family has a stroke I can... I could be able to help or one of the community member needs a help I can help much easier than before...” [Group 1, p. 1].

The first subcategory deals with changes in attitudes within themselves. The second subcategory is about attitudes towards them and changes in dynamics in their spheres of influence; in their homes and communities.

Attitude Changes: There were various expressions of thankfulness to God for having had the opportunity to do the course. They felt the course had benefitted them in terms of personal growth, improved self-esteem, enhanced relationships and the ability to manage their homes better. There was also the aspect of having more respect and a greater sense of value from their families and communities. The opportunity to go to UCT as a student was highly regarded by themselves and their friends and families. Through the process of doing the practical component of the course, there were also some negative attitudes they had to face. Sadly some of these came through the attitudes and misconceptions of other professionals and team members. The biggest of these was the fact that they were treated with less respect than expected. It appeared to them that other professional students were treated with more respect than them.

"It is hard because like I said, we willing, but we are there with extended hand, but they not willing to work alongside with us, that is hard, that is very hard, that is a big challenge that we face, even going to institutions now, you can see we get the cold shoulder, ... you don't know where to place your bag, they don't really communicate with you, but let students come, physio students come from UWC, you can see the way, the difference, and it's like, ... that's hard, that's hard because we face that from day one at any place that we walk into, ... we face it" [Group 3, p. 18].

In the carrying out of their duties they lacked assistance, became exhausted, felt burnt out, lost sleep over concerns about clients and worked hard to improve services. A participant said:

"But it's hard for us as well because we can't like maybe six or seven clients, going from the one home's baggage, you walk into the next, it's a load". "There is one big disadvantage about the course though, because uh, being taught all these skills and opening, broadening your mind, you are not able to just leave a client just like that. You can't, you can't just walk away and leave it. You can't just go home and ... it not (easy) you can't. It's hard because you don't know how to switch off. They say it's easy, your supervisor tells you to switch off, you cannot, it's hard. Now tomorrow morning I would

stand up at two o'clock, hah, this is what I can do (indicating that she had a good idea). It's very hard, so this is a disadvantage. You can't rest" [Group 3, p. 8].

Their expectations of earning more than the current stipend hadn't materialized.

"since we have done this course we have get a lot of achievement, it change our minds, ... it also change the patients' lives, we hope that the government will also think us, of changing our lives now because we work so hard, to improve everything to show the government that we can do everything" [Group 3 p. 18].

While they were CHBCs they had little opportunity for career path improvement. This training opportunity obviously brought with it the expectation of improved salary / stipend. This is the expectation that they had of the government, and it was a motivation for them to give their best efforts to prove their value.

Changes in Family and Community Dynamics: Participants voiced their appreciation and excitement about the way their lives had changed for the better:

"The course also change[d] us because even our families, they are sick, but because we are not in this course we didn't know that our family also have problems. For example my brother, I just notice because I went to the hospital to see the mental people, so we saw the schizophrenia there. So I notice now when I see the things my brother is doing, I just notice no, my brother is hearing voices, and no, I notice that my brother is having schizophrenia. And now my husband want[s] to hit my brother. [He said] '...when I go home in December, I'm going to hit him'. He can't do this! So now I am able to talk to him and tell him you can't hit this person, this person is sick, this is what I am going to do; when I am going home in December, I am going to talk to him because he don't want to go to the clinic, I am going to talk to him then I'm going to take him to the clinic. Now I am able to identify who is sick, who is not sick in the family, yes" [Group 3, p. 15].

One participant tearfully stated that she wished she had done the course before her mother died. She thought she would have been able to help her mother much better. She said:

"I grown a lot with this course, um. I keep on saying I wish my mum was still alive because I struggle a lot you know when I was busy with her. My mom was bedridden and I was the only one who was taking care of her and if I had this course before I keep on

telling myself that she would still be alive. But I know that maybe she'd have gone already, but to me it's as if I didn't do much. I had to send her to the old age home even though I didn't want to, but I had no other option because in the day I was the only one who could take care of her and I had to work and it was just me and my boy but I ...[emotional and crying]¹⁸ [Group 2, p. 16].“ “...even this course it changed my life, even in our community. The people there they call me nurse, social worker, they don't know. If they want they got a problem they say you must go there [to her] you can find an answer but I learn more even in Philani¹⁹ solve too much problem. I can handle even now I refer someone to Philani because I don't have a choice because all people they come someone who don't who have my cell number they call me “we've got this problem, problem ” so I call Philani and they say you must refer...” [Group 1, p. 8].

Thus the changes appeared to have far-reaching ripple effects in their lives. They are enacting change in their personal lives as well as in the interactions they have with their families and communities.

4.4.2 Category Two: 'Changing the Way I Work'

The RCWs found that work was no longer the same. They were different, the way they interacted with other medical staff was different, the way other medical staff interacted with them was different, and their approach to their work was different. They also found work more rewarding. Two of the RCWs had not completed any home based care training. They did however have experience. One of them had worked in the University of the Western Cape Community Rehabilitation Project. The other one had experience working with a community based NGO focusing on early childhood development. Both of these RCWs indicated that there were some things that they needed assistance with in the practical situation. They found this guidance from other RCWs who had done the HBC training, and they indicated that they found it relatively easy to learn these aspects. The two sub-categories below encapsulate these changes.

¹⁸ Support was provided to her during the focus group session, by the researcher, the co-facilitator and other participants. It was a cathartic experience for her, and no further intervention was deemed necessary.

¹⁹ A community based NGO that employs some of the participants

Role Changes in the Multi-disciplinary Team: The following excerpt brings attention to the changes and dynamics they experienced:

"We were able to interact with the doctor and tell the doctor this and that about the client, um the physician would come in and we were actually able to help there, um the speech therapist came in and we could actually give an input there, and they just found that... what are you people?, .. and I think that is when we realized hey, that people can actually see that we have gone to another level from just home based care because that is what we were called at the hospital. And after that just standing aside and just seeing how everyone can see the abilities we had, and that was a good feeling... that's why I said that we are able to interact with every profession there. The nursing staff afterwards they started feeling a bit inferior hey, because they didn't know what we are, they actually said to us, um you are like sharks, we can see you coming and there's nothing we can do about it, because in the hospital, the nursing, that is your profession, you stay just there, you know everyone has got their scope of work, but we could claw around everywhere and we could give our input around everywhere, and they just could not understand that, and that made me feel good." And "I have realized that, um, we are a huge extension in the health profession, a very huge extension for every profession, we make things much easier, you know" [Group 3, p. 3].

A concern needs to be raised that some RCWs may work beyond their level of skill, thinking that they can work independently. One RCW said:

..."we can work without assistance, definitely. We are able to work out treatment plans just by listening to... just by a person's diagnosis. We are able to work out a treatment plan. We don't need to wait on them, [professionals], we can just go ahead and do what needs to be done" [Group 3, p. 10].

It was a concerning issue that other members of the multidisciplinary team often did not understand the RCWs role or scope of practice. At times the RCWs felt left to their own devices with inadequate supervision. This could have led to RCWs taking on responsibilities beyond their scope of practice. The following statement was made by one of the participants:

“We are just introduced that day and then we don’t see them again. We are just left to do what we need to do” [Group 3, p. 10].

Only one such statement was made by a participant, so it might not have been all of their experience. During the feedback session²⁰ which the researchers had with the entire group of RCWs, a few concerns were raised by RCWs concerning their current working conditions and job descriptions. They were being expected to do certain tasks such as escorting clients to other institutions which they felt were not what they were trained for. This indicates that ongoing coordination of the RCWs is indicated especially during this initial phase of their induction and orientation into the services.

Approach Changes: On an application level the data indicated they have the ability to see the bigger picture, to see client’s situations holistically and to look for progress in clients. RCWs reflected that they viewed disability very differently, with raised awareness of people’s abilities. They realized their role as agents of change was important. They stressed that they knew that clients need to be involved in decision making regarding their goals and their progress. This first quotation indicates the broadening of vision:

“...with this training is we can look at person as a whole holistic. Before we just go in and wash the patient. I... I’d assist with baths, full baths, do the wound care, I work also on the clinic as a home based carer at the chronic clinic. But now we can look at the person as a whole, ja, not just the person need to be washed or wound care and there we go we can look at the whole ah person needs” [Group 1, p. 8].

Another approach change is letting clients speak up about their own needs. One participant stated:

“We understand that people with disabilities must be given the opportunity to speak up about their own needs”. I see things different now neh, as far as rehab is concerned. I know now that disabled people must be included in everything now, we must let them express their views, they must say what they want, neh, we can’t just decide for them. We must have the consent from them neh, we must put out the information for them and let them decide” [Group 3, p. 15].

²⁰ The feedback session was held in December 2014, six months after the data collection phase.

The excerpt below demonstrates how an RCW simultaneously gave inputs at different levels. One level was the individual patient, the second was the input to the parents/guardians and the third level was support to other parents of disabled children. Even if not initiated by the RCW, the RCW could adapt and use the intervention opportunity to the benefit of a larger group than just the initial patient and their family.

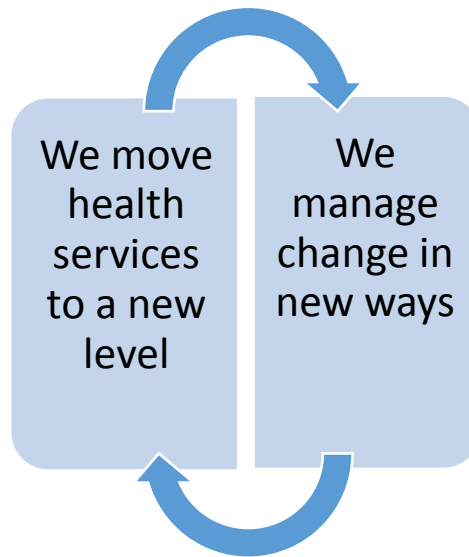
“...and the best part is the people appreciate what you are doing. They will sit and it will form a like a support [group] before you open your eyes because in the road they will say, no the nurses is coming, just come, And then you enter the house and you see new faces you are busy with the speech therapy with the client or a physio or exercises that you are doing then you see there’s more people then she will just say no that is my friends, it’s fine sister you can do it in front of them. It forms a support group because the people whose there have children who have the same illness as the client you are busy with and there’s how they will form a support group they will come together and they will do the exercise which is a good seed that it planted there” [Group 2, p. 7].

This excerpt therefore indicates how valued and trusted the RCWs are. It also indicates that the community feel at ease with RCWs in their homes, and are willing to follow their recommendations.

4.5 Becoming an RCW: A Pioneering Scope of Practice

The two themes operate together dynamically in the narration of the plot, like two sides of the same coin. Both speak interactively to the research question, namely: What are the self-perceived outcomes of the pilot Higher Certificate in Disability Practice (Rehabilitation Care and Support) Course, for Rehabilitation Care Workers? Diagram 4 illustrates the dynamics of RCW pioneering.

Diagram 4: Dynamics of RCW Pioneering



The new competencies acquired by the RCWs brought about improvements in the health services (Theme One). These competencies and improvements required personal changes and changes in the workplace to accommodate them as a new category of health worker (Theme Two). One part cannot alter without impacting the other, and thus a cyclical growth pattern develops. The plot 'we are 'baanbrekers'/pioneers can be enhanced or restrained depending on the merging of these two perspectives. A third essential aspect to the success of the process of introducing a new category worker is attention to the systems and change processes. The findings revealed that the existing systems within which the RCWs function also need to adapt in order to accommodate their emerging scope of practice and that people and systems need time to adapt. The RCWs felt prepared to break new ground. They could however only do so effectively if the ground itself was prepared. Current services and other members of the health team staff needed to adapt simultaneously and this is where the challenge was. The RCWs repeatedly found themselves using a new skill; new to themselves and new to other health workers they worked with.

4.6 Summary

All of the data pointed in one way or the other to this plot. Two essential themes formed the plot; *the first* one represented *what* changed and the second one *how* the changes were managed by the RCWs. Reactions of other health staff to them as a new health cadre of worker

were noted. A wealth of information about the benefits of the course for the RCWs, their families, the communities they live in, the facilities they worked in, the communities they worked in, and for the clients they worked with has been uncovered. A concern about some of the RCWs going beyond their scope of practice is raised. In closing this chapter it was highlighted that the plot can be viewed from two angles. These are firstly, what changed and secondly, how it changed, or the process of how it changed. Both angles need to be considered to make the program viable and potentially contribute to the realization of the WCDohs' outcomes.

The next chapter discusses the interplay between certain themes / categories, and demonstrates the benefits of the training program for occupational therapy, the WCDoh and the National Development Agenda.

Chapter 5 Discussion

5.1 Introduction

The purpose of the study was to inform the curriculum of a RCW training program and the WCDoh of ways in which this cadre of worker could contribute to the realization of the 2030 Healthcare Plan. The 'pioneering' plot that was uncovered speaks of new ground, new people with new skills, new responsibilities, new interactions, and the need for new systems of accountability and supervision. The newness brings with it changes, mostly life enhancing, but with some challenges.

At this point it is necessary to discuss the plot ('baanbreker'/pioneer concept) in more detail, clarifying exactly what makes them 'pioneers'. Firstly, the research describes how the RCW training served as a catalyst of change on three grounds: personal, community and work. It was clear that they face many changes and challenges on all three levels. Secondly, the research provides feedback to the curriculum developers about the RCWs perceptions of the training program. This information can assist in making changes or improvements to the course if deemed necessary. Thirdly, it speaks to the role that occupational therapists, physiotherapists and speech therapists can and should be playing at the CBS level, by supporting and supervising this new cadre of worker. Finally, the findings of the study indicated various ways in which RCWs could contribute to implement the proposed delivery of health services in 2030 according to the implementation of current policy on Re-engineering of Primary Health Care (PHC), (Western Cape Department of Health, 2013). It points to some of the barriers and facilitators to the optimal deployment of the RCWs, who should be understood as an integral part of the health services. Each of these aspects of pioneering and the ways in which the training program acted as a catalyst for change, will now be discussed in relation to the literature.

5.2 A Catalyst for Personal Change

The nature of change brought about through adult learning has been extensively documented in the literature (Macintyre, 2012; Hammond, 2005). Hammond (2005), argues that health and social capital benefits, increased life satisfaction and improved adaptation are part of the outcomes of adult learning. Further work on personal shifts by Macintyre (2012, p. 198) in a study that explored personal change following adult community based training, found that

economic, educational, social and personal progression were all part of the outcomes of adult education programs. Another big change is that it puts people on a path to return to formal learning (Macintyre, 2012, p. 192). The RCWs reported changes that impacted themselves personally, their families, their local communities and their work experiences. Because of their new knowledge and skills, they became more aware of health issues in their own families. They had to deal with current and past issues in their families as their insight developed into new and adapted living skills. The RCWs became preoccupied with the training, sometimes lying awake thinking of how they could help clients. There were also examples given of how they acted outside of work hours in ways that positively impacted disabled people. The training therefore had a huge positive impact on their personal lives.

5.3 A Catalyst of Community Change.

RCWs found that people from their communities came to them asking for input on health issues, and they were able to positively influence their social context. In a study on the impact of CHWs impacting society, Wiggins, et al., (2013, p. 199) state that midlevel workers “can make a significant contribution towards reducing health inequities and creating a more just and equitable society.” They argue that midlevel workers must be trained and supported to play a full range of roles, equipped to use popular education, and supported to value their own wisdom and world views. The broad range of skills and comprehensive nature of the training is thus endorsed in the literature. Other authors (Daniels, 2012; Hammond, 2005) affirm a secondary or indirect benefit of such courses that conforms to one of the wellness priorities of the Healthcare 2030 Policy; that of being to mobilize all of society in making healthy choices. The RCWs are potentially able to influence the communities where they live and work because of their attitudes towards health and disability as well as their ability to model values that promote health.

5.4 Implications for the Health Service

The training of midlevel workers is intended to add value to the provision of health services in terms of improved access, equity, effectiveness, quality and sustainability (Schneider, 2012); this is the very essence of South Africa’s National Department of Health Mission (South Africa Department of Health, 2012). Health policy directives endorse the primary health care approach.

One of the core principles of the push to re-engineer primary health care is “to attain a population-orientation approach to health care, focused on meeting priority health needs of geographically coherent populations in a comprehensive manner, including prevention, promotion and good quality, essential care” (Western Cape Department of Health, 2013, p. 8). The findings suggest that RCWs may support this core principle. This study uncovered the ways that the RCWs were catalysts for change in various ways, as detailed in the sections below.

5.4.1 A Catalyst for Improved Interdisciplinary Teamwork

The RCWs had to embrace a new work role and deal with the dynamics of being a more prominent member of a health professions team. They had to interact with categories of staff they had never interacted with before, and who often did not understand their various roles and functions. They had to manage the fact that they were often treated as HBCs while they were in fact no longer HBCs. Their role and function was not always understood, which meant they had to forge their own place among the health professions team members who were, at times, surprised by their skills. Nevertheless, the RCWs felt they were not treated with the respect they deserved. This could be for various reasons, including a poor understanding of the role and abilities of RCWs, or a sense of feeling threatened with regards to their own place in hierarchical workplace structures.

In a study by Baker, Egan-Lee, Martimianakis and Reeves (2011), it was found that members of individual professions are likely to protect their own sense of identity when interacting in inter-professional education (IPE). This defensiveness can interfere with collaboration and patient care.

In Ghana, the CHWs are held in high regard in the communities they serve (Lehman & Saunders, 2007). The findings of this study indicated that while the RCWs were held in high esteem amongst their families and immediate community, they, nevertheless, faced prejudice by health personnel in certain health institutions. The RCWs contribution to the NDP would therefore hinge, to some extent, on the way that other health professions accept them, and are willing to work with them in a team (Pinto, et al., 2012).

The RCWs have identified certain aspects of their engagement in the health services where attention needs to be given in order to promote their integration into the system. The RCWs felt

inadequately respected for the service they were able to render. This aspect requires attention by the appropriate institutions and management. The literature suggests that the institutions at which the RCWs work should consider education and training of all staff categories on the role and function of the RCWs (Pinto, et al., 2012). In addressing these issues, Pinto (2012, p. e75), proposes an integration model that involves, “regular team meetings, opportunities for access to colleagues, and the promotion of consultation between colleagues, and that attention to inclusionary ways of working can improve integration of community based staff and facility based staff.”

Snyman, Von Pressentin and Clarke, (2015), propose the use of the ICF as a catalyst for inter-professional education and practice. It has proven to be a “catalyst for authentic patient-centred learning experiences, shared by different health professionals (Snyman, Von Pressentin & Clarke, 2015, p. 6)”.

5.4.2 Catalysts for Task Shifting.

Task shifting is another benefit that the RCWs bring to the WCDoH. Task shifting is the delegation of some healthcare tasks to less specialized health workers who require shorter training periods. Campbell and Scott (2009) discuss six lessons learnt about effective task shifting: the need for strong management, appropriate selection, suitable training, adequate retention structures, good relationships with other healthcare workers and the ‘community embeddedness’ of CHWs.

This research has found that the RCWs have the potential to contribute to Healthcare 2030 implementation by enhancing the CBS and the intermediate level of care. Although the community municipal ward-based multi-disciplinary health teams are not established, some of the functions of these teams are already being carried out by RCWs and HBCs. The clients that the RCWs serve have access to their broader range of health skills. Some of these health skills can be performed at the clients' homes, others are within the community setting and others at the intermediate level of care. All of these skill sets improve access to, as well as the quality of, health services. They promoted a seamless service, as they enhance care at intermediate level as well as HCBC level (Western Cape Department of Health, 2013). Additionally, they were able to facilitate the step up referral process from community to the intermediate level of care. They successfully managed specific clients at community level under the supervision of rehabilitation professionals. RCWs therefore enabled effective task shifting during their period of training.

5.4.3 A Catalyst for Deployment of RCWs

Daniels (2012) in her doctoral thesis and multiple studies on lay health workers, cautions against the deployment of lay health workers as part of a formal health system. She says that they need significant support and supervision from a well-organized health system. She comments on the potential for them, especially as they are mostly women, to be exploited and not well looked after. The current HBCs and RCWs are not lay health workers as they are being paid stipends, have job descriptions and work in a formalized system. However they are not professionals either, they are not employed directly by the WCDoh and the danger exists of less than adequate support and supervision.

The RCWs are placed in the WCDoh institutions or CBS services and are supervised directly by WCDoh staff and intermediate level healthcare facilities' staff. Although not completely unique, this is uncommon, and the formal supervision and support structure can potentially pave the way for new and innovative ways of deployment of RCWs.

5.4.4 A Catalyst for Improved Access to Health Services

In Ghana, Rwanda and Brazil, CHWs have been instrumental in improving access to health services, improving health outcomes and improving quality of care (Drobac et. al., 2013; Pinto et al., 2012). The RCWs improve access to health services by being involved in early detection and referral of people potentially needing health care. They were able to identify problems in the community and people's homes, which otherwise might not have been detected. They were much better equipped than HBCs due to their understanding of mental health, disability and early childhood development. Their ability to understand the importance of why and how to refer was invaluable. They were versatile; being able to work at the community level as well as the intermediate care level.

5.4.5 A Catalyst for Improved Supervision and Support at CBS Level.

The RCWs require regular support and supervision as they are not qualified to work independently. The RCWs are on the front line daily where they deal with the harsh realities of sickness, disability, social stressors and poverty. In order to sustain a healthy motivated workforce it requires ongoing, regular care of the RCWs. During the period of data collection, this ongoing care was being facilitated by UCT program facilitators, but it ended in June 2014.

They are currently working in various institutions and in community settings where supervision and support is not standardized. A limitation found in the current health policies, is the fact that no rehabilitation professionals are stated to be directly involved in any of the three streams of the re-engineering of PHC (Western Cape Department of Health, 2013). Most, if not all of the training of the RCWs was performed by rehabilitation professionals; the supervision of the RCWs during their practice learning and current placements was done by rehabilitation professionals. The essence of their skills lies mostly within the field of rehabilitation professionals, and thus accountability for their work will fall on rehabilitation professionals. Therefore, the absence of recognition for the role of rehabilitation professionals in the current national or provincial policies is a serious concern with regards to the future deployment of RCWs, and the sustainable quality of the service they must render.

Supervision was, at times and in certain institutions, inadequate and led to a number of problems:

Firstly, it led to them working beyond their scope of practice. This is serious, as it can lead to client harm, the essence of what the Hippocratic Oath aims to prevent.

Secondly, it did not promote interdisciplinary teamwork, and good collaboration between professions. There remained the underlying thread throughout this research that the RCWs skills were not understood or appreciated and this led to the RCWs feeling disrespected and feeling they needed to prove themselves.

Thirdly, during the feedback session the RCWs raised new issues not related to the research. These were related to job descriptions and their current work environments. It is vital that ongoing consultation and collaboration as well as further research is done in order to promote the optimal introduction of this potentially highly effective new cadre of worker in the Western Cape.

5.4.6 A Catalyst for Fulfilling of Mandates of Service Delivery

The Western Cape Department of Health has upheld its constitutional mandate to provide accessible health care services by initiating this training initiative. The findings support the National Negotiated Service Delivery Agreement in three of the six focus areas (Western Cape Department of Health, 2013, p. 5):

Firstly, the findings confirmed that the RCWs worked in PHC services where they acted as an extension of the health workforce in client centred care. HCBC is designed to create an interface between the population and the health service, and is proven to improve quality and better health outcomes (Western Cape Department of Health, 2013; Pinto et al., 2012; Saunders, 2009). The strengthening of “Intermediate Level of Care allows for a seamless transition between the acute services and the persons living environment” (Western Cape Department of Health, 2013, p. 40).

Secondly, health care financing and management may be enhanced because the cadre worker is potentially a very good investment. The literature indicates that the main reason for establishing CHW and MLW programs is to promote effectiveness by promoting access, improving health outcomes, and improving quality of health care services (Mwita, 2010). According to Pinto et al., (2012) and Prinja et al., (2014), cost effectiveness can also be achieved. Lehman and Saunders (2007), warn however that CHW programs when run properly and sustainably are not cheap; they should not be seen as a cheap alternative, but rather a very good investment.

Finally, the RCWs were able to demonstrate an enhanced awareness of the need to provide quality services to their client’s due to the nature of their comprehensive training approach which is rehabilitative, preventive, promotive and curative. These aspects of healthcare are priorities of Healthcare 2030. According to Healthcare 2030, (Western Cape Department of Health, 2013, p. 38), “areas of particular interest for expansion in the Western Cape are health promotion and preventive and rehabilitative care”

5.4.7 Implications for the implementation of the National Development Plan

The findings point to ways in which the implementation of the training program and introduction of this new cadre of health worker could facilitate, amongst others, an improvement in people’s access to health services (National Planning Commission, 2011). Mayosi and Benatar (2014), on “Health and Healthcare in South Africa 20 years after Mandela,” argue for trained community health workers to translate health service policy into practice.

One of the objectives in Chapter Ten (Healthcare for All) of the National Development Plan 2030 (National Planning Commission, 2011), refers to the deployment of Primary Health Care Teams that will provide care to families and communities. This is one of the three main streams of PHC

implementation (Western Cape Department of Health, 2013). It is envisaged that RCWs will participate in community municipal ward-based multi-disciplinary health teams, thus supporting the re-engineering of Primary Health Care. The policy is clear that the ward-based teams will have a ratio of one nursing sister to six CHWs, (a health promoter and environmental health officer will also be part of the team when possible). The policy mentions a ratio of one RCW to 8 CHWs, although it lacks clarity of which setting this refers to. The other two main streams are the district based clinical specialist teams and the school health services. Neither of these will include rehabilitation professionals directly. This is in contrast to the technical report (Schneider, 2012, p. 59) which states that supervision must be by rehabilitation professionals. Thus the three streams of re-engineering PHC will not directly have rehabilitation professionals. Currently the RCWs are required to be supervised by rehabilitation professionals which raises questions with regards to the policy. As such, it is important for this issue to be addressed, in order for the ward-based team approach to be efficient.

Management of community-based rehabilitation programs is complex (Lehman & Saunders, 2007), and health professionals and CHWs are often relegated to find their own way. It was confirmed by this study that RCWs were in some ways responsible for forging their own path. This did lead to RCWs working beyond their scope and the possibility remains of causing harm to patients. The ideal would be for rehabilitation professionals rather than nurses to be supervising RCWs on the ward-based teams, as rehabilitation professionals are trained not only in rehabilitation but disability prevention, health promotion and curative care. The WCDoH should be cognizant of these cautions when deploying RCWs.

South Africa has ratified the Standard Rules on the Equalization of Opportunities for Disabled People (Standard Rules) (WHO, 2001). The WCDoH has the obligation to adhere to the requirements in these rules. As the RCWs are rehabilitation workers and trained in disability inclusive development, some of their work should reflect adherence to some of these rules. Below is a reflection of how the RCWs contribute in several of the relevant rules. In rules 1 to 12, the RCWs contributed as they:

- made significant attitude changes towards people with disabilities and have become advocates to raise awareness in their communities on disability issues;
- participated in early identification and health promotion programs;

- were available in the local community where the person with disabilities lives;
- considered access issues as part of holistic patient care;
- were able to do early identification of special education needs;
- were instrumental in screening and referral of clients for vocational programs,
- raised awareness for people with disabilities concerning rights to access social assistance programs;
- promoted engagement in cultural, religious and sports activities;
- promoted full participation in family life of people with disabilities.

Thus, it is clear that the training program itself is an appropriate response to rule 19 pertaining to staff training (WHO, 2001).

5.5 RCW Training: Implications for the Curriculum

The RCWs perceived the course content as appropriate, and targeted at the right level for the participants. Only three aspects for improvement were noted: more attention to dealing with the blind, helping the deaf, and doing resource mapping. This feedback will be provided to the course conveners, however, the direct and indirect feedback by the RCWs was overwhelmingly positive.

What learners take with them from a course is more than the content of the curriculum (Williams & Williams, 2011). The impact of the trainers' attitudes and ability to motivate the RCWs must not be underestimated. The observable passion that RCWs have for their work did not just come from the theory, but from a well presented course with enthusiastic trainers. The trainer who is enthusiastic, energetic and genuinely interested in both the subject and conveying his or her message, will evoke the greatest response from the trainees (Williams & Williams, 2011, p. 18).

So what are the implications for the further roll out of this curriculum? The results of a study by Pinto et al., (2012), in Brazil, recommend interdisciplinary and trans-disciplinary collaboration, which should start at undergraduate level. This could be a key to indicating that the course should be integrated with medical schools, where close collaboration, and interdisciplinary education and practice can be facilitated.

The training of RCWs is strategically linked to the goals of Healthcare 2030, specifically the strengthening of the CBS component which includes the intermediate level of care (Western Cape Department of Health, 2013). With such a crucial plan at stake, the curriculum, training, and implementation must be exactly on target. Wiggins et al., (2013, p. 199) state that community health worker training must include training and support in the workers' 'role[s] as social change agents.' The way CHWs are trained influences the roles they play. The study further recommends that training in values should be part of the curriculum and that experienced community health workers should be involved in the training (Wiggins et al., 2013, p. 198).

According to the South African Committee of Health Sciences Deans (2012), South African Higher Education Institutions are committed to a two year program for profession specific MLWs as they recognize the need for task shifting and expertise at community level as well as the need for appropriate and effective supervision and mentoring of such workers to ensure best practice at district level. The HPCSA does not recognize MLWs with a generic broad skills base. They only register profession specific categories such as occupational therapy assistants/technicians, and physiotherapy assistants/technicians that are coupled to a specific profession. This has possibly hindered the development of a cadre of worker such as the RCW for decades. There is a need for the HPCSA to be more flexible to the acceptance of this type of curriculum which is clearly a 'needs-based' curriculum that can contribute to South Africa's health and developmental agenda.

5.6 Implications for Occupational Therapy

The RCWs new abilities in the fields of rehabilitation, disability inclusion and health promotion, mean that they are well positioned to be allies of rehabilitation professionals especially occupational therapists. In particular the promotion of independence in activities, and participation in societal life, is relevant to occupational therapists. Similarly because these aspects of healthcare are being expected of them, the RCWs can be well guided and supervised by occupational therapists (South African Committee of Health Science Deans, 2012). Occupational Therapists, as all other health professionals, need to reflect on their attitude towards RCWs and embrace them as allies in striving towards promoting health for all (Chappell & Johannsmeier, 2009).

Besides occupational therapy's strong focus on activity limitations and participation restrictions the profession also has a strong grounding in the bio-medical model. Occupational therapists should therefore be good initiators and supporters of the implementation of inter-professional team work, including the use of the ICF as a communication and collaboration tool. Occupational therapists should therefore be key people in the process of bringing this new cadre of worker on board in the health system. Research has indicated that strong management and supportive supervision are essential ingredients in the success and quality of community health worker programs (Campbell & Scott, 2011). This places an onus on occupational therapists and others responsible for supervision to ensure the success and quality of RCW program implementation.

The need for community based rehabilitation practice protocols and standards has been highlighted by Petrick, Sichangwa, Collinson, and Pickford, (2002). According to Petrick, et al., (2002), the lack of these practice protocols and standards made the critical role of supervision more challenging in community setting. Occupational therapists could therefore be instrumental in developing these protocols specifically for the Western Cape context, especially in the absence of a South African CBR policy.

Chapter 6 Conclusions

6.1 Introduction

The main purpose of this study was to determine the perceptions of the RCWs on the training they received to up-skill them to be RCWs and to use the information to give feedback to the curriculum developers. This research has found that the RCWs have the potential to significantly contribute to Healthcare 2030 implementation by enhancing the CBS and the intermediate level of care. Although the community municipal ward-based multi-disciplinary health teams are not established, some of the functions of these teams are now already being introduced out by newly appointed RCWs. The communities that RCWs work in have access to their broader range of health skills. Some of these health skills can be performed at the client's homes, others are within the community setting and others at the intermediate level of care. All of these skill sets improve access to health services and improve quality of health services.

6.2 Recommendations for the Western Cape Department of Health

The RCW training program has therefore introduced a momentum of change in the WCDoH. The challenge remains to keep this momentum going, allowing it to influence deeper and deeper into the cogs of the health system so that the benefits can be felt at all levels of care.

6.2.1 Recommendation One: Recruitment and selection

The WCDoH should continue to recruit people who have completed community and home-based care training. The data indicated that the RCWs who did community and home-based care training before doing the RCW training had fewer adaptations to make. However the person who obtained the highest marks was not previously trained in CHBC. Thus some flexibility should be allowed.

6.2.2 Recommendation Two: Salaries

The WCDoH should continue to upgrade the RCWs stipends after completion of the course. The RCWs expected to be upgraded in salary benefits after completing the course. At the time of the data collection this had not yet happened and there was disappointment amongst the RCWs.

Between that time and the current writing, their salaries have been adjusted upwards. The RCWs expectations of this benefit have, therefore, been met. This is important for sustainability.

6.2.3 Recommendation Three: Orientation and Induction

Introducing this new cadre of worker effectively and efficiently into the health services required appropriate orientation and induction of all staff involved which, according to the RCWs, was inadequate. This led to the RCWs having to, at times, forge their own path. This is one of the reasons for the title of the plot. It was not within the scope of this research to find out how best to manage this process, but it is an area where the WCDoh will be able to contribute specifically when the next intake of students is placed for practice learning or employment.

6.2.4 Recommendation Four: Inter-professional Education and Collaborative Practice

The WCDoh should endeavour to promote strong inter-professional teamwork between all relevant professionals and this new cadre of worker. Proper collaboration can improve quality of healthcare (Lehman & Saunders, 2009). The literature has indicated that training of all professionals from undergraduate level on inter-professional collaboration will help in this regard (Pinto et al., 2012). Literature also indicates that communities can become strong and active partners in CHW programs. Communities can select, motivate and supervise CHWs if a linkage is provided to health programs (United States Government Evidence Summit, 2012, p. 31). The use of the International Classification of Functioning, Disability and Health (ICF) has in other studies, provided a systematic, though non-mechanical means of engaging with patients, carers and inter-professional team members (Snyman, Von Pressentin & Clarke, 2015, p. 6). The ICF has the ability to enhance “respect, collaborative leadership, job satisfaction, trust relationships and accountability between team members, as well as a culture of on-going learning (Snyman, Von Pressentin & Clarke, 2015, p. 6)”. The use of the ICF in assessment and in outcomes (evaluation), is therefore recommended as a catalyst and facilitator in developing good inter-professional practice. Models of practice using the ICF are available (Snyman, Von Pressentin & Clarke, 2015). The use of the ICF as a tool for facilitating improved inter-professional practice and teamwork is recommended as it is a tool that can be used by all health professions and is an established internationally understood tool that can promote inter-professional learning and collaboration. The ICF and the outcome measures linked to it such as

the WHODAS (WHO, 2007; WHO, 2000) can also be used to measure outcomes and monitor progress of clients.

6.2.5 Recommendation Five: Supervision of RCWs

The model for current and future RCW supervision appears to require attention. The RCWs trained and worked under rehabilitation professionals for the duration of the training program, and continue to do so at the present time. For the planned three streams of primary health care all of which will entail RCW deployment, a supervision structure that includes professional therapists must be drawn up, as this is absent in the WCDoh strategic planning documents. The RCWs felt inadequately respected, un-supported and under-supervised at some of the sites where they did their placements for practice learning. This aspect requires attention by the appropriate institutions and management. The literature suggests that the institutions the RCWs work at, should consider education and training of all staff categories on the role and function of the RCWs (Pinto, et al., 2012). In addition there remains a lack of clarity with regards to their supervision in the available WCDoh documents. Certain documents state that rehabilitation professionals will supervise them, and other documents state that nurses will do it. The important success of this pilot for the Healthcare 2030, indicates that this aspect should receive attention. Due to the fact that the domains of practice of activity limitations and participation restrictions as well as disability inclusion, overlap strongly with the profession of occupational therapy, the researcher recommends that occupational therapists should be primarily responsible for their supervision.

6.2.6 Recommendation Six: Task shifting

Task shifting should be approached with considerable forethought, collaboration, strong management and good supervision structures. In this study there was evidence of defensiveness on the part of some nursing staff, which is something that can be avoided through training, facilitation of effective communication, good supervision structures and teamwork (US Government Evidence Summit, 2012). RCWs support task shifting of some rehabilitation and disability inclusion services. However this will require dedicated experienced rehabilitation professionals support, as well as continued collaboration between Higher Education Institutions, the NDoH and the HPCSA, in order to produce sustainable results.

6.3 Recommendations for Future Research

6.3.1 Inter-professional Education and Practice

One pertinent aspect needing further study is how to promote collaborative practice between professionals and RCWs. Collaboration needs to be separated distinctly from supervision, as these are two separate elements. There is potential to use the ICF as a tool to promote inter-professional education and practice. The ICF can be used as a monitoring and evaluation tool because the domains of the ICF are the domains that the WCDoh aims to work on, and the RCWs were also trained in them. The use of the ICF in practice has the potential to create the environment where a much broader perspective of health is realized. Appropriate outcome measures linked to the domains of the ICF can enable accurate and appropriate monitoring and evaluation with a focus on the goals of Healthcare 2030, as these goals are linked to the domains of the ICF. Research can help to develop outcome measures, enhance evidence based practice and enhance the health systems pertaining to the roles of the RCWs.

6.3.2 Practice Guidelines and Standards

Evidence based practice has been mentioned as a shortfall of CHW programs (Schneider, Hlophe and Van Rensburg 2008). The development of practice guidelines and standards of practice for RCWs field of practice will be beneficial to make the outcomes objective, and provide evidence of success or failure of such a program (Petrick, Sichangwa, Collinson, and Pickford, 2001).

6.4 Limitations of the Study

The RCWs are CHWs with rehabilitation and disability management skills. This made the literature search at times problematic, as this is quite unique. The available literature separates CHWs from CBRs quite distinctly. However there were similarities in the general purposes of CRWs and CHWs, making the literature applicable to RCWs.

Many of the RCWs were Afrikaans or Xhosa speaking. This could have limited the input from persons who were less fluent in English, as the focus groups were held in English due to this being the most commonly understood language.

The study did not include all the RCWs to the same extent, as only 18 of the 29 participated in focus groups. Generalization of the data to all the RCWs is therefore not possible.

6.5 Summative Statement

The pilot group of RCWs believe that they are competent in a new and large variety of skills that have enabled them to make a broad and positive impact in their places of work, at home and in the broader community. They perceive themselves as well equipped to compliment the CBS and intermediate level of care in the Western Cape. They are thus potentially equipped to promote the achievement of some of the Healthcare 2030 goals.

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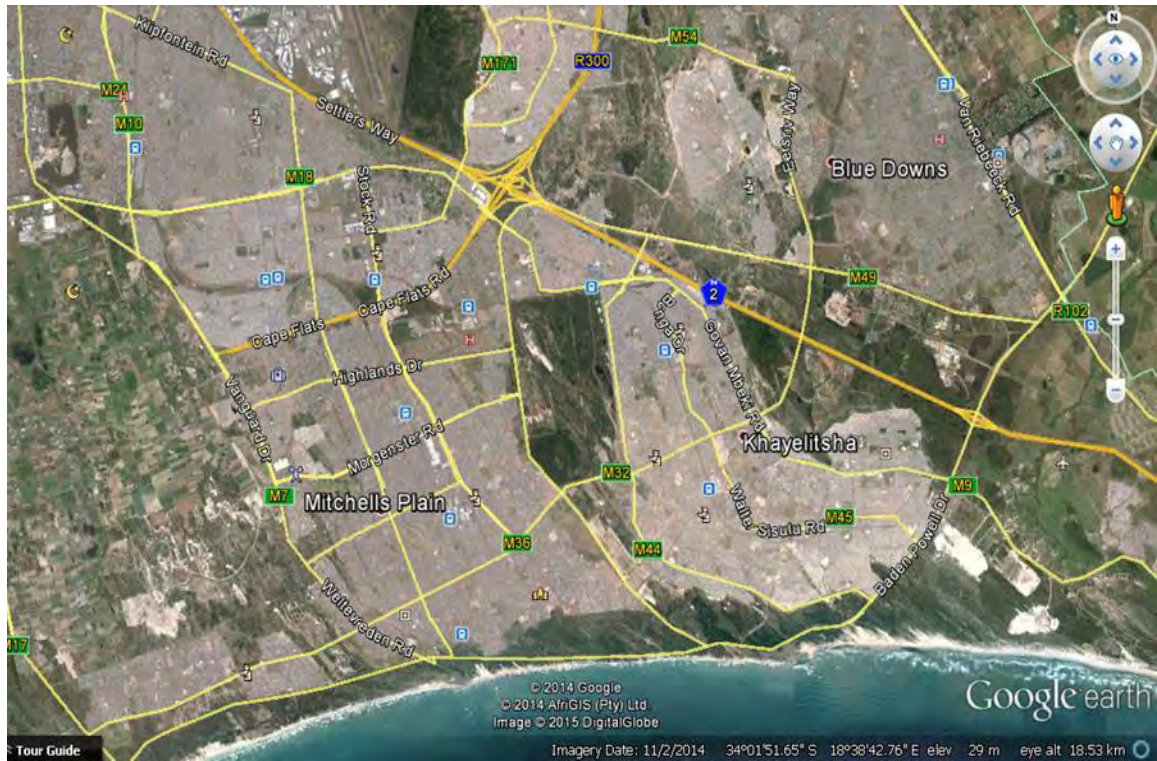
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APPENDIX 1: Aerial Map of Mitchell's Plain and Khayelitsha



APPENDIX 2: List of Questions for Focus Groups

- Has the way you work changed since doing the course, and if so why?
- What were the benefits of the course for you in your work?
- What aspects of the course do you feel you did not benefit from and why?
- Was it helpful or not, to first do the HBC course and then the RCW course, and if so why?
- How do you view recordkeeping? Why?
- What do you see as the benefits of the course for yourself as a person? And why?
- What did you learn on the course about the attitudes of disability workers?
- Talk about specific benefits the course had on your understanding of your role in a multi-disciplinary team.

APPENDIX 3: Ethics Approval



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



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05 February 2014

HREC REF: 088/2014

Ms S Maart
Health & Rehab
F-Floor, OMB

Dear Ms Maart

PROJECT TITLE: REHABILITATION CARE WORKERS PERCEPTIONS OF THE BENEFITS OF A PILOT TRAINING PROGRAMME

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee for review.

Please note that the student cannot be the PI, we have therefore changed it to reflect the supervisor's name. The student will be recognised on all communications.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 28th February 2015

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/research/humanethics/forms)

We acknowledge that the student, Mr Graham Clark will also be involved in this study.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal investigator.

Please quote the HREC reference no in all your correspondence.

Yours sincerely

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN ETHICS

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC ref 088/2014

APPENDIX 6: Example of Transcription with Codes Identified

really um have to get the help of us as a rehab workers cos sometimes they are just playing there loose for instance theres a small boylike there by us in the area he's got a disability he's limping and then he they call him whopple and you know childrens mindset was also changed cos they used to call him whopple the whole time then I said why you call him whopple they said ja cos he whop whoop the whole time so I said no he's got a beautiful name and they all started to call him now Jayden on his on his um name and um I said why you call him whopple he's got a beautiful name just see how and sometime now sometimes it also the negligence of the parents cos they also don't clean the children property then the children look so dirty and all look down on this child so I took him from the street and I cleaned him I washed him and I dressed him nicely from somer from my daughters clothes was like a unisex stuff then I dressed him up and I let him go out they said "jo whopple jv lk um kwaai" so I said here we as the rehab workers also had to give an input in the children or the communities life so they can also see the change and um so also um this how do you call it now um this stigma that break the stigma 11:45

p1: Even even me she was working the community Tafelberg but she was there in the Khayelisha she was not walking properly so she was not use the working frame shes only sitting in the room in her chair but now as ???to to??? but to but how can you do in the ???in the client to educate the people ??? the time was to walk using the walking frame you your ?mother? you must stand up and putting the the walking frame and walk walk don't not have the always to sit in the wheelchair and not go outside to buy something like chips so ?????????? shes right by me ?change a lot of the community

p2: even the exercise that you can do at home for ah paraplegic we at first you overlooked it we see that person is just laying there but now seeing that we are constantly busy we learn that the right way how to do the exercise we improve the life and the living of that patient they on stand up they can move out of the bed onto the wheel chair how to do a trunk rotator a twist rotation it is very important because you learn how to strengthen his upper body because he has to use his upper body to move around even if theres no he feel no life in his legs you still have to do exercises hulle by resistance you hold onto the knee while you do the exercises because of the spasms and a lot of people if they see um someone get a spasm they got a fright they thought he's going into a fit then as a row we have to explain to the family its not a fit its just normal and then you show them how to do the exercise call the children the big children call them come stand here and see what I'm doing I'm away there's a weekend ahead then you know how to do it you even educate the patient himself because he can talk he will tell them "no the sister did it for him that way thats a ?wrong way come to do it?" cos like one patient of mine he did go to Wellington for a weekend it was the first time it was very bad and ah monkey in a tree we call it a monkey bar because its for him to strengthen his upper body he said I was laying and I wonder what thing is this you see even the nurses or the physios they don't explain to the patient why they use that equipment if somebody bring a ball I never seen a ball in my life I make an

example and I put it in front of me I would now know what must I do with it I will just stare at it and ignore it cos I don't know its something you can pick up or kick it's the same with a paraplegic if you don't explain to him what you gonna do why it is there and I???? said to him come come come I'm not gonna help you take your hand and bring yourself up which he did and he said "jo sister" and I said yes because of the wound they didn't hes been there 3 months they didn't give him any physio they only do the wounds and that is that you have to see to the other needs of the patient also they know because in the folder everything is written up but the doctor write do the wounds that they overlook the other parts. And he said "jo sister I feel better" come make more and I said no come come use it and he said at first "I cant" I said "no you have to read between the lines because the patient can play you as well because they get away for so long you have to be firm strict and firm but gentle and the best part of it when he come Monday he said "sister it's the first time in my life I went out of this hospital I ask him "where were you" to Wellington to his sister his sister is a staff nurse but still she don't even have the time to do the exercises and my concern was you went home who did your wound? ok your sister a nurse she will do the wound but the exercise many nurses do only what they must do but they not worried about the exercise you see and he said "sister you know what I call her children "I said how old are they" 25 31 said "ok" and what did you do? sister I feel like a larvae because I can show them and guide them "come do the exercises sister do you must do it so and so and I mean by the end of the day as an row it makes you feel proud because you take note what you learn the theory you learn at UCT you can practice it and he can do it he can do it himself he said "sister I'm up now I can sit up for the spasm I can press my knee down and I can do it myself I keep it there but I cant use my toes but I'm not worried " you see he can his body parts to support himself which is very good 18:17

p3: even with children um when you see the child you can now quickly identify where theres developmental delay or where theres a disability due to um just observing the child and um sometimes you don't even need to ask or or or um you can just look at the child and see for instance like we had the de um developmental um stages and from there we can now see what is the um the um complete development station where it is that the child has got um a delay and ah when I went o um St Josephs now I had a child and I just look at the child this child looks so small I wonder now what is this childs age and then I could see that shes got ah developmental delay cos shes now 21 months and shes still sliding on her butt shes not crawling or shes not standing up and now I could go back to the developmental um stages and I could help her get into the real the right um developmental um stages to go like she had to like crawl before she can stand up and um even um help her cos shes got a problem with her one hand I could even help her with her hand whenever she like crawl I just lift up the hand that she can put the weight on the hand where we normally would like just ignore the child and let the child play there normally in the community it happens like this that that normally just leave the child um they like ignorant to what the the childs need is but now you can as the row student you can apply these things to the children and help them to get to the right um development stages

dealt with disability awareness
break stigma of disability
promote Disability awareness
physically we overlooked paraplegics cannot exercise for paras deal with spasms train family to do exercises what I do
para relax

gap/misinformation Education for para relax
I.D. relax
put theory into practice
observe progress
I.D. D.D.
understand development stages
para relax
misinformation development

Second Example of Transcription with Codes Identified

Title: Rehabilitation Care Workers Perceptions of the Benefits of a Pilot Training Programme

Transcription of focus group 1. Friday 16 May 2014 12h00 to 13h15.

Before the group started Graham explained briefly how the group will be run, repeated the importance of confidentiality, explained the need for name stickers with numbers, did introductions, and asked if anyone had questions. The only question asked was concerning whether feedback will be given after the group. Graham explained that feedback will be given towards the end of the study analysis.

Start:

6

Graham. 1: So the first question we want to discuss is "has the way you ... has the way you work, the way you do your daily work, changed since doing the course, ... and why has it changed?"

P6: Yes for me its changed because... mmm i'm working in community before without knowing about the... therapy but now if i am helping the client or a patient... like for example here is a stroke i know what must i do to the patient... And before i did the counselling but... i'm... not always using my counselling course but now in the facilities that came you need to... firstly to help the patient and to make the patient to understand what i am talking about, what i am doing.

G: Are those some of the skills you learnt on the course, or before the course ... the counselling course ... to do for the client.

P6: mm but one week only.

7:22

G: What do other people feel?

P4: For me i felt... before i started on this training, i was having home base only, so i knew how to wash and change the nappy of the patient, but now i have more experience on working on disability people so i... know how to work on the stroke patient... know how to work on the... let's say someone is intellectual disability so i know how to handle the person, before i didn't know how to act when someone has the disability, but now i'm... more equipped than before i was, so it helped me a lot in changing the way i was before, now i can work in everywhere, even if my family one of my family has a stroke i can... i could be able to help or one of the community member needs a help i can help much easier than before... so, that's help me a lot in ???... 8:31

P3: For me it's very important because it was my first time ????? i didn't do a homebased career, i'm doing L.I. when i am working at ???. So when i come to this course i learnt too much skills even when someone have got a stroke i know how to assist them. Even at home (there's another woman??) got a stroke i'm doing everything because of this course and i'm not afraid because i know what i did. 9:04

G: Thank you

P1: Can i also say that even for myself i have been in the rehab before i did the course... but for me the importance of the exercises because we did the exercises but we didn't do it the correct way and we didn't know (background mmm)... When when when the physios speak they speak about adduction and abduction and you are thinking okayay but you are not really sure what it means. But now you you are able to identify that name with what you are meant to do and also to explain to the client the importance of the exercises, what the benefits of the exercises are what it can do for you. So for me it is, it is yes it has been very beneficial not just in the exercise but in different like the disability intellectual disability because it is a bit um or mental disability it is a bit... scary before you don't wanna... you don't wanna have clients that have that. But now it it you more comfort i think comfortable and um also (cough) excuse me with the... resources within your community you you find people with a variety of disability in one house. so now you can identify oh this is this i know where i can refer this person to or i know what to do in this case. So it has really been... beneficial. to me. 10:35 (okay - Fadia?)

P2: For me the benefit of the course is that cough i think that um disability affect everyone everyone. we must not just think it affects the people that you see there but... it affects me also because it can happen to me as well. um?? for me to deal with that life don't have any guarantees anything can happen. so to be equipped and be knowledgeable about that is with that cough for me is um is a good opportunity for me that i can share this information with other people not just for myself my children my family... uu in our community. So it is very good skills ??? i think that you can transfer over the information ??? (noise in background cant hear speaker) with the disability and oh ja mental illness uh uh intellectual disability before i didn't know uh quite what the um it consists of but now i'm knowledgeable about it and i can um be open minded about it and ja i think if we don't know if we don't know we stay in the dark about it and you don't know how to cope and deal with it in the situations and (getting out?) cough you end up worse than you have become. i think. So its good that people get knowledge about it and get information about it. and how to cope and deal with it on a daily basis. 11:59

G Do you, just to for clarity you are talking about getting worse. the you mean the patients or yourself. you talking?

P2: well i look at it in a broad way, look at it a broad way because. at my patient and a a because i came from a a a relations i was in a marriage where my husband was like a ????? mental illness was schizophrenic but i must tell you was very i was in the darkness about it but now i am aware of it. So if i have to have a patient then i know how to deal with it. + illness.

G: great 12:36

p5: to me... it was useful because before. when i come to visit the houses i see different illnesses like ah the person cant talk. We did didn't know even look at the person because we don't know how are we going to help that that that patient. And also the mental illnesses... we didn't even look at that because we are just get frightened... how are going to help this person. So we just don't look but um um we don't help the family of that a but now we know the resources where can you transfer the the a family you you educate the the the families about that client. all that i get it from the from the from the course. 13:37

know where to refer it's.

educate family.

APPENDIX 7: Information Letter

Information letter:

Introduction: Dear Community Care Worker:

My name is Graham Clark; I am an Occupational Therapist, doing my Master's Degree in Occupational Therapy at UCT. As part of the completion of my degree, I need to complete a research assignment.

The research is being done to ensure that the training program you are participating in, achieved what it intended, and that it has benefitted you.

The title of the research is: Rehabilitation Care Workers' Perceptions of the Outcomes of a Pilot Training Program

The purpose of the study is to get input from you, the Community Care Workers who have participated in the training program, in order to determine how it has changed your daily practice. It is essential for us to get your input, as you are the only ones who can provide us with the information. The results of the study can be used to increase the effectiveness of the training course. The training program you are participating in is a pilot project in one of the substructures, with the intention to extend it to the other substructures of the Cape Town Metro, and provincially. No one else but you can be targeted for this research, and you can therefore play a role in improving the program for future participants.

The research process will require you to participate in a group discussion for about sixty minutes and with a maximum of eleven other people. Topics of your practice and training will be discussed. It is not an exam process with wrong or right answers. A minimum of one such group will take place. The group discussion will be recorded. This recording will be typed up. A follow up group session of about sixty minutes will be held with the same group of people, and the recorded results will be reflected to you, to make sure that the information that was gathered is a correct representation of what was discussed. This information will be analysed to determine what changes the training course has enabled you to make in your daily practice. Feedback will be given to the trainers, so that the course might be improved in the future. The study might also be published.

The information will only be used for the specified current research project, and will possibly be published. If there is an intention to use the information for any other purpose, then additional consent will need to be obtained from you, and further ethics approval will need to be obtained. A presentation will be done once the study is completed, for you to see and hear the results. It will be an interactive session where you can give your opinion on the results and the recommendations.

The benefit to you as a participant will be the opportunity to reflect on your practice and learn from other participants, and having the knowledge that you are adding value to future programs, and thus to future clients. There will be no financial incentive to participate in the groups. If during the discussion it becomes apparent that you will benefit from debriefing, counselling or other social or medical intervention, then such referral process will be discussed with you, and should you agree to it, the referral made to the most appropriate source of such a service.

The group participation will require you to share your experiences with the other people in the group. The facilitators will be professional people who have experience in running groups, and will at all times facilitate discussion that will not cause embarrassment, distress or other harm to all participants. All input in the group will be treated with respect, and respect will be one of the group guidelines.

All discussions will be confidential. This means that no one's name will be linked to any of the data when the data is recorded. There will only be an interest in the content of the information. As the information will be gathered in a group discussion, it will be expected of everyone present to adhere to strict confidentiality rules. Confidentiality will be a requirement for participation in the group discussions. In other words, you may not repeat what someone else has said in the group to anyone after the group has been completed. Group discussions will be recorded in audio as well as audio visual format, in order to ensure that information is correctly captured. The video recording is focused on the researcher and not the participants. The recordings will be erased as soon as the necessary capturing of information is completed.

Tea, coffee, cool drinks, and biscuits will be available to participants. Any travelling costs to get to and from the venue will be reimbursed. The groups will occur during working hours unless otherwise agreed. No deductions from your salary will be made for participation in the research.

There is no obligation whatsoever to participate in the study. There will also be no penalties for not participating. You also have the right to withdraw from the study at any time, with no repercussions to you. You do not need to provide any reasons for withdrawing from the study. All participation in the study is voluntary, and no insurance/compensation is available in the case of injury.

You are warmly invited to participate in this research. Your input, as a member of the first pioneer training program, will be highly valued as you can make a vital contribution to an improved course, to the benefit of patients and future Community Care Workers in the Western Cape Province.

You may also contact my supervisor, Madie Duncan at any time should you have any questions. Her Tel number is [0787320546](tel:0787320546).

Thank you in anticipation.

The researcher's contact details are: Work: 021 931 0211/2 ext. 123. Cell: 082 216 0335

Email: graham.clark@westerncape.gov.za My workplace is: Elsies River Community Health Center, Halt Road, Elsies River.

APPENDIX 8: Consent Form

Consent form:

Research Study: Rehabilitation Care Workers; Aspects of their training that most influenced their practice.

I _____ have read (or had read to me by _____) the Information Sheet. I understand what is required of me and I have had all my questions answered. I do not feel that I am forced to take part in this study and I am doing so of my own free will. I know that I can withdraw at any time if I so wish and that it will have no bad consequences for me.

Signed:

Participant

Date and place

Researcher

Date and place

APPENDIX 9: Confidentiality Form

Confidentiality form:

Research Study: Rehabilitation Care Workers; Aspects of their training that most influenced their practice.

I _____ have read (or had read to me by _____) the Information Sheet. I understand what is required of me and I have had all my questions answered. I agree to keep confidential everything that was spoken of in the group. This means that I will not repeat to others outside of the group what was said by other persons, including the facilitators.

Signed:

Participant

Date and place

Researcher

Date and place